AULTCARE

Return to: AultCare Insurance Company
Attn: Retention Department
P.O. Box 6910, Canton, OH 44706
retention@aultcare.com

ANNUAL DETERMINATION OF GROUP SIZE DEMOGRAPHICS

Employer Name / Legal Name of Company

Group Number

Employer Identification Number (EIN / TIN)

EMPLOYEE COUNT ANALYSIS

PLEASE REVIEW THE ATTACHED SHEET FOR ADDITIONAL GUIDANCE

1. Does the attached **Related Employer Analysis** define your company as part of a controlled group or affiliated service group? _____Yes _____No

   a. If yes, list the other Related Employer name(s): _____

   b. If yes, consider that fact when answering all of the questions below.

2. Provide the following current employee counts (including all Related Employer counts):

   _____Full-time _____ Average number of seasonal/temporary employees for current year

   _____Part-time _____ Other (briefly describe: _____)

3. Provide the number of employees currently eligible for health insurance benefits: _____

4. For COBRA eligibility, employers must have **at least 20 employees on more than 50% of their typical business days in the previous calendar year.** Refer to the attached COBRA Analysis section and provide the following employee counts:

   _____Full-time _____ Part-time (Each is counted as a fraction of a full-time employee.)

   _____Total number of employees

5. For Medicare Secondary Payer (MSP) purposes:

   a. Did you (including all Related Employers) **have 100 or more** full-time, part-time, seasonal employees or partners on **50 percent or more of your business days** during:

      i. The current calendar year? _____Yes _____No

      ii. The preceding calendar year? _____Yes _____No

   b. Did you (including all Related Employers) **have 20 or more** full-time, part-time, seasonal employees or partners **for each working day in each of 20 or more calendar weeks** (weeks do not have to be consecutive) during:

      i. The current calendar year? _____Yes _____No

      ii. The preceding calendar year? _____Yes _____No

      iii. If you checked "Yes" for the **current calendar year, and the 20-employee threshold was met during the current year,** provide the date: ____ /____ /____.

I understand AultCare is relying on my answers to the above questions to ensure overall compliance for my group health plan. I also understand the information submitted will be used to determine: whether Medicare will be the primary payer of claims for my Medicare-eligible insured(s), employer size for continuation of coverage, and employer size status under State and Federal regulations. I certify the answers are true to the best of my knowledge and belief. I also understand I am responsible for promptly notifying AultCare (as indicated above) if my answers to any of these questions change because our organization has increased or decreased the number of employees. I understand that CMS penalties may apply.

Signature of Company Officer or Authorized Representative

Print Name

Title

Date