univera HEALTHCARE
an excellus company

Group Information Form Instructions

Includes assistance to the most commonly asked questions

Section One

3. *Tax Identification Number (EIN/TIN)*
   The Employer Identification Number/ Taxpayer Identification Number (EIN/TIN) can be found on your annual or quarterly tax forms. (e.g., Form 1065, Form 1120, NYS-45, etc.) The SIC code is a four digit code indicating which industry your company is classified as doing business in. If you need assistance in determining your company's SIC code or would like more information, please go to https://osha.gov/pls/imis/sicsearch.html

5. *Group Number*
   The group number can be found on the first page of your Univera Healthcare insurance bill, in the upper right corner.

6. *Business Physical Address*
   Enter the address where the business is located, this should not be a P.O. Box.

7. *Address of Company Headquarters*
   If the address of the company headquarters is different than the business physical address noted in the previous question, enter the address where the company is headquartered from.

10. *List Owner(s)/Partner(s)*
    Note all owners, partners, and shareholders by first and last name. If more room is needed, you may add a separate page listing all individuals.

11. *Indicate if your company is organized as a:*
    If the company is a stand-alone business with no other ownership affiliations to other entities, please select "Stand Along" and proceed to the next question. Otherwise, please indicate the business relationship with those other companies and complete the information about those related entities.

14. *Is there a group medical plan in place in addition to the products offered through Univera Healthcare:*
    When identifying other group medical plans, please only include group health insurance plans, omitting any life insurance or similar supplemental insurance.

    "*New York State of Health*" refers to the New York State Marketplace.
    "*Other*" refers to a different health insurance carrier.

Section Two

1. *Average number of owners and employees at all locations (all full time and part time employees) for prior year*
   This pertains to the federal government's requirement to identify the average number of total employees within each group for the purposes of medical loss ratio reporting. If this number fluctuates, please add the number of people employed each month and then divide the total by twelve to get the average.

Section Three

1. *Number of eligible active employees and owners*
   Include any employers, partners, or owners who are offered health insurance coverage, even if they are waiving coverage.

2. *Number of retirees (not on Medicare) eligible for the employer group plan*
   Include all retirees who are eligible to enroll in the same plan as active employees or a retiree health plan. Be sure not to include those individuals enrolled in a Medicare plan. Those individuals are to be counted on the Supplemental Medicare Form.

3. *Number of individuals enrolled in COBRA/New York continuation of coverage and/or the young adult option*
   Include any individuals who have experienced a qualifying event and have elected to continue their health plan coverage through COBRA or NYS continuation of coverage. If applicable, also include dependents enrolled in their own policy through the young adult option.

4. *Total number of eligible individuals for group health insurance coverage*
   Add questions 1, 2, and 3 to get the number of total individuals. If this calculated sum is 3 or less, please include your most recent NYS-45.

5. *Total number enrolled in the health plan*
   Enter the total number of eligible individuals that are currently enrolled in the group health plan

6. *Participation percentage*
   Divide the number of enrolled employees from question 5 by the number of eligible employees in question 4, then multiply by 100.

Full Time Equivalent (FTE) Calculation Aid

Under the Affordable Care Act, groups are now to be categorized by their Full Time Equivalent (FTE) calculation. Please use the table below as a guide for calculating your group's FTE count. Please do not submit this form, as it is solely a guide to help you obtain the correct calculation. Do, however, write in your group's final FTE number onto the Group Information Form in Section 3 Question 12 under the Medical Full Time Equivalent Calculation portion.

For additional assistance, please follow the links below.

http://www.irs.gov/Affordable-Care-Act/Employers/Determining-if-an-Employer-is-an-Applicable-Large-Employer

http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

	Number of Hours Worked by Part Time Employees		*Number of Full Time Employees*
January		*January*	
February		*February*	
March		*March*	
April		*April*	
May		*May*	
June		*June*	
July		*July*	
August		*August*	
September		*September*	
October		*October*	
November		*November*	
December		*December*	
Total (#10)	*A.*	*Total*	*C.*
	÷ 1,440		*÷ 12*
Total Full Time Equivalents (#11)	*B.*	*Total Full Time Employees (#7)*	*D.*

Total Full Time Employees + Full Time Equivalents (#12)

{Add B + D} Round Down to the Nearest Whole Number

The information reflected in this document is intended only as general information to assist you in determining your group's size under the Affordable Care Act and the definition of small employer under the NYS Insurance Law starting in 2016. It is not intended as legal or financial advice or opinions. Persons seeking specific guidance concerning the Affordable Care Act, the Internal Revenue Code or New York State laws or regulations should consult with their attorney, Certified Public Accountant or other authorized consultant or advisor. These contents should not be construed as, and should not be relied upon for, legal or tax advice in any particular circumstance or fact situation.

Contribution Section

Product Name
List all of the medical products your offer in this column. If your employer group exceeds the number of products in the provided space, you may need to complete an additional form for the additional plans.

Subgroup Number
Indicate the Subgroup number that is associated with this contribution amount. It can be found in the top right corner of your monthly bill under Subgroup ID.

Class Name
If your contribution strategy differs by class, please list the employee class in this column and provide the information for each. The standard class names are listed on the form. If it is not on the list, please indicate the class name in this section. If your employer group has more than four classes of employees, you may need to complete a separate form for the additional classes.

Contribution Type
Indicate whether the employer group contributes a flat dollar amount ($) or a percentage (%) towards each employee's monthly premium.

Employer Contribution by Tier
Please enter an amount for the Employee tier, regardless of which tiers currently have enrollees. For each applicable tier (Employee & Spouse/Employee & Children/Family), indicate the dollar amount or percentage amount contributed from the company.

HSA/HRA Employer Contribution
If you have a health savings account (HSA) or health reimbursement account (HRA) attached to your high deductible health plan, please enter the dollar ($) or percentage (%) of the annual amount your business contributes towards the deductible.