KAISER PERMANENTE®

NEW FORM REQUIREMENT – SMALL GROUP

COBRA, Mini-COBRA, Senior Advantage Eligibility

Why am I receiving this form?

Kaiser Permanente of Georgia requires confirmation that your company meets the definition of a large or small group for purchasing health care coverage. This information is also used to calculate and report Medical Loss Ratios (MLR) under governing regulations 45 CFR 158.120(a) and 158.103.

What action do I need to take?

Please complete and return this form to your Account Management team to determine eligibility for a Senior Advantage, COBRA or Mini-COBRA coverage.

What if my business has grown?

To qualify for new small group coverage, an employer must have an average of at least one but no more than 50 eligible employees on business days during the immediately preceding calendar year.

Employers that have grown and now qualify for large group coverage may remain in the same small group plan and can be automatically renewed **if** their current plan is retained with **no** changes.

Questions?

Please contact your Account Manager.

Refer to **healthcare.gov/shop-calculators-fte/** or your own legal counsel for instructions on how to accurately calculate the number of employees required on the form.

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SMALL GROUP EMPLOYEES CONFIRMATION FORM

Company Name			Customer ID
Office Phone	Ext.	Email	

SMALL GROUP EMPLOYEES CONFIRMATION

I confirm that the company identified above ("Company") meets the definition of either small group or large group under the applicable law as indicated below. I further confirm that to the extent "Company" is made up of two or more entities that are "commonly owned" as defined under applicable federal law, "Company" meets the definition checked below.

○ **Small Employer** OR ○ **Large Employer**

I further confirm that the numbers below are accurate for the previous calendar year:

_____ Total number of full time **and** full-time equivalent employees counted in compliance with the Affordable Care Act (26 U.S.C. sec. 4980h (c) (2) (E)) and any applicable state law for purposes of determining the employer size checked above

_____ Total number of employees on payroll (full time & part time, regardless of eligibility) for all entities

_____ Total number of employees on payroll that are eligible under the Summary Plan Description and in accordance with applicable state and federal law for the group coverage you are purchasing

Please refer to healthcare.gov (for the first calculation) or your legal counsel for information on calculating the above totals.

RELATED ENTITIES CONFIRMATION (Request to combine related entities for this coverage)

Indicate below whether or not you are requesting to combine related entities for this coverage.

○ **No**, I am covering only one legal entity under this coverage (if you are only covering one legal entity, please leave the table below blank.

○ **Yes**, I request to cover more than one legal entity under this coverage. I have listed the entities that would be covered under this policy and I confirm that all the entities listed meet the legal requirements to be treated as a single employer under subsections (b), (c), (m) and (o) of Section 414 of the Internal Revenue Code. **Please complete the table below**.

Business Name	Employer Identification Number

SIGNATURE

By signing this form, I acknowledge that this confirmation may be subject to verification and agree to provide Kaiser Permanente with any necessary information to do so. I affirm that I have authority to contract with **Kaiser Foundation Health Plan of Georgia** and **Kaiser Permanente Insurance Co**.

Authorized Company Signer Name (please print)	Title (please print)
Signature **X**	Date