CHARTER HEALTH PLAN

A big idea for small business

EMPLOYER VERIFICATION FORM

Group Name & Address:	**Group Number:** **Renewal Date:**

PART 1 – EMPLOYEE CENSUS SURVEY

Full Time	Part Time	Continuation	Waiting Period	Total
				Total Eligible Employees ___________

Employee Medical Coverage Summary – Please provide a count for each category below for all eligible employees:

Charter Health Plan	Spouse's Medical Benefit Plan	Other Medical Benefit Plan	Waiving – No Medical Benefit Plan

PART II – EMPLOYER SURVEY

1) Please indicate the average number of eligible employees within the previous 12 month period: ___________
2) Have you employed 20 or more full or pat-time employees for 20 or more weeks during the current or preceding calendar year? ☐ **Yes** ☐ **No**
3) Have you employed 100 or more full or part-time employees on 50% or more of the business days in the preceding calendar year? ☐ **Yes** ☐ **No**
4) Please indicate your rate of contribution toward your employee's health benefits:
   Single: ☐ 50% ☐ 75% ☐ Other ______%
   Dependent: ☐ 0% ☐ 50% ☐ 75% ☐ Other ______%
5) Do you, as an employer, cover your employees under Worker's Compensation? (If yes, please provide documentation as proof of coverage in conjunction with your response.) ☐ **Yes** ☐ **No**

PART III - SIGNATURE

I hereby attest to the accuracy and truthfulness of the above information. I understand that if the information I have provided is not accurate and complete, my company's health benefits coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Owner/Officer or Authorized Company Representative:	**Telephone Number:**

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Print Name:	**Date Signed:**

Group Name & Address:

Response Required: Policy will be renewed with Standard Rates if complete response is not received 15 days prior to the renewal date.

Dear Charter Health Plan Employer,

It's time to renew your Charter Health Plan coverage. As part of the renewal process each year, we verify your eligibility as a Florida Small Employer. The process is as simple:

1) COMPLETE ALL SECTIONS OF THE ENCLOSED EMPLOYER VERIFICATION FORM (EVF).
    a. Indicate the total number of all employees in each category requested.
    b. The total number of employees includes those who may be covered under any other health benefits plan (including continuation coverage or Medicare).
    c. The total number of employees includes any employees of affiliated employers. (If you file a combined tax return, you are considered one employer.)
    d. If you are an Owner or Sole Proprietor and employ no one else, the total number of employees is one.
2) INCLUDE YOUR MOST RECENT UCT-6 TAX AND WAGE FORM.
    a. We consider this information in confirming your eligibility as a Florida Small Employer and to ensure compliance with community rating laws.
    b. If you are a Partnership, Owner, or S-Corporation, confirm your eligibility Schedule K-1, or IRS Form 1099 for each contracted employee.
    c. If you do not furnish one of the above, furnish either your previous month's Payroll, or a letter from your Attorney or CPA listing of the names of employees, their Dates of Hire, and the Hours worked.

IMPORTANT

- Verify that the preprinted name and address of your company are the legal name and address for your company. If the preprinted information is no longer correct, please write the correct address on the EVF.
- Do not risk non-renewal of your policy by leaving out any of the information requested.
- Do not risk non-renewal of your policy by delaying your response past the **Response Due Date**.

Charter Health Plan
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