Health Net®

Employer Group Size

Verification Form

Health Net must collect this information to comply with many different regulations. ***You, the employer, are responsible for notifying Health Net of any changes occurring during the course of a calendar year that could impact your employer size determination related to Medicare Secondary Payer or Health Care Reform.***

Please complete the form in its entirety.

Employer name – legal name of company:			
Physical address:	City:	State:	ZIP:
Group/Parent ID or policyholder number:	Employer Taxpayer Identification Number (TIN):		

Total number of full- and/or part-time employees: _____ as of _____.

Please provide the largest applicable number. In making your selection, consider your organization/company's total number of employees world-wide, regardless of location or eligibility for health care coverage.

Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: _____

An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.[1]

To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12 (or # of months in business if less than 12 months). Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

Has your organization been part of multiple employer group health plans? ☐ No ☐ Yes
If "Yes," please provide dates, names, TINs, and addresses:

_____

_____

_____

I understand that Health Net is relying on my answers to the above questions for accurate reporting to CMS under Section 111 guidelines and Health Care Reform. I certify that the answers provided are true and correct to the best of my knowledge and understand that I must promptly notify Health Net of any changes to the above information.

Group administrator signature:	Print name:	Date:

Please return the completed form to Health Net by either faxing it to (818) 676-7411 or mailing it to:

Health Net Membership Accounting and Eligibility Department
CA-100-04-03
PO Box 9103
Van Nuys, CA 91409-9103

If you have any questions, please contact your broker or Health Net account manager. Thank you for your support.

[1]This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.