Employer Verification Form

To determine if you qualify as a Small Employer under federal or state health coverage reform legislation, we must have current and accurate data regarding the total number of employees that you employ. Please complete this form by following the instructions below.

When reporting the number of your employees below, please note the following:

You must include **all** employees:

1. for all your work locations, whether or not you are/will be offering them health coverage;
2. whether or not they actually enroll for coverage and regardless of whether or not they currently have medical coverage or through whom that coverage is provided.

NOTE: If you are a **New York** employer, and if you have Union Employees, ONLY INCLUDE those employees who are eligible for coverage under the Aetna plan.

If you are a **Maine** employer, indicate below if part-time employees or retirees are to be included as eligible employees under the Aetna plan.

Legal Name and Address of Company	Control Number (if a current customer)

Please indicate below the number of employees by the state in which they work. All employees must be included, regardless of whether or not they currently have medical coverage or through whom that coverage is provided.

Work Location (list by State)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e. temporary, substitute, seasonal)

If your group has fewer than 10 employees who are eligible for coverage under your plan, please provide the following information

Total number of Employees ________

Total number of Employees waiving Aetna health benefits but covered through their spouse's health benefit plan. ________

Total number of Employees waiving Aetna health benefits coverage without coverage elsewhere. ________

Total number of Employees covered under another health benefit plan offered by the employer ________

Prior Coverage Information **(For New Applicants Only)**		
1. Current carrier	2. No. of years with current carrier	3. If no current coverage, how long without coverage

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that if the information I have provided is not accurate and complete, my company's group health coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. I also understand that at any subsequent annual renewal, the number of eligible employees that I have will be audited to assess the applicability of all applicable health coverage legislation.

Owner/Officer or Authorized Representative of the Company (Signature and Title)	
Print Name	Date Signed

[This form will not be accepted if incomplete or if its content has been altered]