

Employer Verification Form \ Underwriting Certification Form

To determine if you qualify as a Small Employer under federal or state health coverage reform legislation, and if you meet Aetna U.S. Healthcare®'s (Aetna) requirements for participation and contribution requirements 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.

Legal Name and Address of Company	Control Number (if a current customer)
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Please provide the following information regarding your employees:

Total number of Employees _____		Total number of employees eligible for health benefits coverage _____
Total number of Employees waiving Aetna health benefits coverage without coverage elsewhere _____		Total number of Employees waiving Aetna health benefits but covered through their spouse's health benefit plan _____
Total number of Employees covered under another health benefit plan offered by the employer _____		Total number of employees waiving Aetna health benefits coverage because they are covered by a different employer's plan _____

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.

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

Please list all current medical carriers including Aetna.

1. _____ 2. _____ 3. _____ 4. _____

What amount do you, as an employer, currently contribute to your employees' health benefits?

Single 0% 25% 50% 75% 100% Other **Dependent** 0% 25% 50% 75% 100% Other

Do you anticipate a change in your contribution as a percentage of premium for the coming plan year? If yes, explain.

Legal Name and Address of Company	Control Number (if a current customer)
<p>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. I understand that if my company does not meet Aetna's participation and employer contribution requirements, Aetna may choose not to offer a renewal of coverage, and that Aetna will monitor ongoing adherence to participation and employer contribution requirements prior to subsequent renewals, subject to the requirements of state small group reform laws and the federal HIPAA law. 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.</p>	
Owner/Officer or Authorized Representative of the Company (Signature and Title)	Date Signed
Print Name	Telephone Number:

If you employ 50 or fewer employees, please also attach a copy of your most recent state wage and tax statement. Below are the requested forms by state.

CA (DE-6)