Aetna Employer Verification Form

_____
_____
_____
_____

Account Number: _____
HMO: _____
PPO: _____
Renewal: _____

PART I - EMPLOYEE CENSUS SURVEY

Employee Breakdown by State - Please provide a count, by state, for each category below for all employees eligible for coverage:

State	Full-Time Count	Part-Time Count	Retiree Count	Continuation Count	Other Count	Total
				Total Eligible Employees		

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

Medical Benefits Plan (Aetna)	Medical Benefits Plan (Other Carrier)	Spouse/Partner's Medical Benefits Plan	Other Employer's Medical Benefits Plan	Waiving Medical Benefits Coverage

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 part-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: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ Other: _____%
Dependent: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ Other: _____%

5) Do you, as an employer, cover your employees under Worker's Compensation? (If responding 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that if the information I have provided is not accurate and complete, my company's health benefits coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. 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.

Signature of Owner/Officer or Authorized Representative of the Company:	Telephone Number:
Print Name:	Date Signed:

* Please Note: Plan sponsors in the state Georgia, please indicate total eligible employees for the previous 3-month period.