Alaska Group Size Determination Form

This form must be completed for all new and renewing groups to determine whether a group is a small or large employer.

Group Name	
Are you a Controlled Group? If you are a controlled or affiliated group of employers as described under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, Moda Health must treat all employees within the affiliated group as a single group for purposes of determining group size. You must fill out one group profile form for the entire controlled group. If a controlled group is determined as a large employer, each affiliated employer is part of the large employer even if separately the employer would not meet the definition of large employer. Therefore, each affiliated employer is considered a large group for the purposes of group size determination.	☐ Yes ☐ No

Employee Counting Instructions	
A. Total the number of employees working 130 hours for each month of the preceding calendar year. **B.** Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. This is your Full Time Equivalent (FTE) count of the preceding calendar year. **C.** Add A + B, then divide the total by 12. This is your group size. *Note: When counting employees to determine group size, do not count a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or the spouse of a person who is a sole proprietor, a temporary, seasonal, leased or contracted employee, a retired employee, or former employee on continuation coverage.*	
1. Employee Count (Determines Group Size) Please enter the average number of common-law employees who were employed during the previous calendar year (January–December). If less than 1, no Alaska small group exists. If more than 50, the group is a large group and not eligible as an Alaska small group. If 1 to 50, the group is a small group. This count should include full-time, seasonal, and union employees that work inside or outside the State of Alaska, or any employees affiliated company. Include business owners, corporate officers, and partners only if they are common-law employees. Contracted 1099 individuals should not be included. "Common-law employees" are defined under the Employee Retirement Income Security Act of 1974 (ERISA) and Internal Revenue Service (IRS) as an individual who qualifies as an employee based on traditional employer-employee relationship principles, primarily determined by the level of control the employer has over the worker. Consult with your legal counsel to ensure that your employees are considered common-law employees under the law.	
	Employee counts
2. Out of the number of employees mentioned above, indicate the number of employees waiving due to other group or individual coverage	
3. Total employee count (for participation requirement) (#1 - #2):	
4. Out of the number of employees indicated in question #3, indicate the number of employees opting out of coverage:	
5. Total number of employees enrolling (#3- #4)	

Employee Participation

What percentage of employees participate in the plan(s)? (#5 divided by #3)

Medical:

- For groups of 1-4, minimum of 100% of eligible employees must participate.
- For groups of 5-50, minimum of 70% of eligible employees must participate.
- For groups of 51+, minimum of 70% of eligible employees must participate.

Non-voluntary Delta Dental Only:

- For dental only groups of 2-4, minimum of 100% of eligible employees and eligible dependents must participate.
- For groups of 5-50, minimum of 70% of eligible employees and 25% of eligible dependents must participate.
- For groups of 51+, minimum of 70% of eligible employees must participate.

Voluntary Delta Dental:

- For groups of 2-50, minimum of 2 enrolling employees and 25% eligible employees.
- For groups of 51+, minimum of 25% of eligible employees must participate.

Signature

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

I am the: ☐ **Business Owner** ☐ **Group Administrator** ☐ **Authorized Insurance Agent** ☐ **Other**

Name (printed please)	Signature	Date
X		