# Employer Group Size Attestation

Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits,® Inc. (collectively referred to as CDPHP®) requires groups to attest to the following items: their group size and availability of essential pediatric dental coverage. Your prompt completion and return of this form to CDPHP, Attn: Group Services Unit, 6 Wellness Way • Latham, NY 12110 is greatly appreciated.

**NOTE TO LARGE GROUPS: You must complete, sign, and date the CDPHP Employer Group Size Attestation (#1 below.)**

**Group name**: _____

**Federal tax ID #(s)**: _____

**Group number**: _____

**Group effective/renewal date**: _____

**Broker name (if applicable)**: _____

**1. CDPHP Employer Group Size Attestation—For Small and Large Groups**

Under New York law and the Affordable Care Act (ACA), the definition of "small group" is 1–100 full-time equivalent (FTE) employees. To assist you in calculating how many FTEs you have, go to www.dfs.ny.gov and enter "small group expansion" into the search box.

**CDPHP is requesting that you attest to the size of your group in order to ensure that it is classified and rated accurately. By completing this form, the group hereby attests to the following: (Please check one)**

◯ Large Group, as defined by New York law and the ACA (more than 100 FTEs in the prior calendar year)

◯ Small Group, as defined by New York law and the ACA (1–100 FTEs in the prior calendar year)

*Pursuant to 29 C.F.R. 2510.2-3(b), an "employee benefit plan" does not exist if no "employees" are covered by the plan. Pursuant to 29 C.F.R. 2510.3-1 and 29 C.F.R. 2590.732(d) an "employee" does not include the sole owner of a business or a spouse of the business owner.*

◯ Grandfathered group (as defined under the ACA), and the new definitions of large groups and small groups do not apply.

**The group further attests that:**

- It has calculated the number of employees using the guidelines set forth by New York and the ACA;
- It has accurately reported this number to CDPHP for purposes of underwriting insurance coverage for this group;
- It understands that CDPHP is relying on the group's disclosure of this information for accuracy and proper classification as large group or small group;
- It understands that it must comply with New York law and the ACA, and other laws to the extent applicable, and that the group's failure to comply with these laws on their effective dates could result in serious penalties being imposed on the group, and/or CDPHP, in addition to litigation, complaints, and other actions being brought against the group, and/or CDPHP

  CDPHP reserves the right to audit a group's records related to their attestation that they are a large group or a small group. CDPHP shall give the group 10 days' notice of their intent to audit the group, and CDPHP shall be responsible for any and all reasonable costs associated with this audit.

## 1A. Total Employee Count—CMS Primary/Secondary Payer Calculation

Please provide the total number of part-time and full-time employees over the prior calendar year*:

_____

**Total number of employed individuals, not total number of people covered under the plan. Visit CMS.gov for more information.*

## 2. Controlled Group or Affiliated Service Group Attestation—For Small and Large Groups

*By completing this section, the group hereby attests that they are a Controlled Group or an Affiliated Service (Please check one)*

◯ **Controlled Groups (IRS Code sections 414(b) and (c))**

Group size under a Controlled Group is determined based upon the total FTEs for all entities. In order to combine separate groups into one employer group for group insurance purposes, CDPHP will require documentation that 80% of each entity is owned by the same person or set of people.

**Please check if any of the conditions apply:**

◯ Multiple tax identification numbers are listed above.

◯ This/These groups are owned by another entity.

◯ This group owns another entity.

◯ This group is one of multiple groups that are owned by the same entity/entities.

*If any of the above conditions apply, tax documentation certifying at least 80% common ownership must be submitted. Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule) with the names of all entities OR (2) Schedule K-1 (Form 1065).*

**Please list the names of all members of the controlled group:**

_____

_____

_____

_____

_____

_____

◯ **Affiliated Service Group (IRS Code section 414(m)).**

**Please indicate what documentation you are supplying to verify the group's status as an Affiliated Service Group and include noted documentation with your submission of this form:**

_____

_____

_____

*(Include additional sheets if necessary)*

**Please list the names of all organizations that are part of the affiliated service group:**

_____

_____

_____

## 3. Essential Pediatric Dental Coverage Group Attestation—For Small Groups Only

◯ **Small Group (1–100 employees)** ***(complete section 3 below)***

◯ **Large Group (100+ employees)** ***(essential pediatric dental coverage is not required)***

In an effort to make health care more accessible, the Affordable Care Act (ACA) requires that all small group health plans provide coverage for a range of core services known as Essential Health Benefits (EHBs), one of which is pediatric dental care. This form may be submitted to membership@cdphp.com.

**Enrollment and Billing**

CDPHP is helping to ensure our members with small group health plans have this essential coverage. If you select a Delta Dental group plan through CDPHP, we will enroll your employees and their covered dependents in the Delta Dental Pediatric Dental Plan. You will be billed for all enrolled individuals (subscribers and dependents).

**Optional Attestation**

If you are providing your employees the essential pediatric dental coverage from another plan not offered by CDPHP, you have the option to opt out from the Delta Dental Pediatric Dental Plan through CDPHP on behalf of your employees. By signing below, you are attesting that you are already meeting the essential pediatric dental coverage requirements through another plan, and you are disenrolling your employees from the CDPHP pediatric dental coverage through Delta Dental.

**Group name**: _____

**CDPHP group ID#**: _____

**Name of company issuing the standalone dental coverage**: _____

**Effective date of the standalone dental plan**: _____

## Agreement

I certify that I, as an authorized designee of the above-named employer group, have obtained standalone dental coverage that provides a pediatric dental essential health benefit to my employees and their dependents through a NY State of Health™-certified standalone dental plan offered outside NY State of Health.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge. 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for such violation.

**Print Name:** _____

**Signature:**_____ **Date:** _____