SARASOTA MEMORIAL HEALTH CARE SYSTEM

CHARTER HEALTH PLAN

A big idea for small business

EMPLOYER VERIFICATION FORM

Group Name:	**Group Number:** **Renewal Date:**

PART 1 – EMPLOYEE CENSUS SURVEY

# Full Time Employees	# Part Time Employees	Total # of Employees	Waiting Period	# Hours for Full Time Status

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

# Employees on the Charter Health Plan	# Employees on Spouse's Medical Benefit Plan	# Employees on Other Medical Benefit Plan	# Employees Waiving – No Medical Benefit Plan

Total # Eligible Employees_____

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 pat-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:
   Employee: □ 50% □ 75% □ Other _____%
   Dependent: □ 0% □ 50% □ 75% □ Other _____%
5) Do you, as an employer, cover your employees under Worker's Compensation? (If 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that if the information I have provided is not accurate and complete, my company's health benefits coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. 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 Company Representative:	**Telephone Number:**	**Group Address:**
Print Name:	**Date Signed:**	**City, State, Zip**