



# EMPLOYER GROUP SIZE CERTIFICATION

SIGNIFICA INSURANCE GROUP, INC.  
ATTN: POLICY ADMINISTRATION  
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800-796-7460  
Fax #: 717-581-1319

To comply with federal requirements and to ensure the proper administration of your plan, please complete all sections of the form, sign, date and return to the address above.

## Section 1 – Employer Information

Employer Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Date: \_\_\_\_\_

The information you provide should include employees for all locations and divisions within your organization (if applicable).

## Section 2 – Medicare Secondary or Primary Payer Information

PLEASE ANSWER ‘YES’ OR ‘NO’ TO THE FOLLOWING BASED ON TODAY’S DATE:

In either this year or the previous calendar year, my Company employed 20 or more employees (including part-time employees) for each working day for a duration of 20 or more calendar weeks.      Yes      No

My Company employed 100 or more employees (including part-time employees) on 50% or more of its regular business days during the previous calendar year.      Yes      No

## Section 3 – Mental Health Parity and Addiction Equity Act Compliance

PLEASE ANSWER ‘YES’ OR ‘NO’ TO THE FOLLOWING BASED ON TODAY’S DATE:

My employed an average of more than 50 employees during the preceding calendar year.      Yes      No

## Section 4 – Duration of Eligibility

Eligibility for coverage under your Significa group health policy is conditional. To preserve coverage, an employee must be actively working at a designated job for the number of hours required to satisfy the full-time eligibility requirements that your organization has placed on file with Significa. Coverage must terminate on the day that an employee no longer meets those requirements unless your organization has a written leave policy that has been pre-approved by Significa and placed on file with Significa. The written policy must outline for how long and for what reasons an “inactive” employee will remain covered on the group policy. (Examples may include employees on disability leave, approved leave, temporary layoff, and reduced work schedule.) If there is no pre-approved written leave policy on file, an employee’s coverage will terminate on the last day he or she worked the number of hours required by your organization to maintain full-time eligibility for coverage. **Changes to your leave policy may be made by contacting our Policy Administration Department at 1-800-796-7460.**

## Section 5 – Dated Signature and Title of Corporate Officer/Partner/Owner

**Pennsylvania:** 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 the criminal and civil penalties.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Virginia:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I certify the above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_