# RECERTIFICATION FORM FOR SMALL GROUP RENEWALS

**Group Name:**

| |
|---|
| Group Name: |
| Federal Tax ID: |

**Group Administration Details: See attached Underwriting Guides for employee definitions and calculations**

| |
|---|
| **A.** Total number of Full-Time Employees: |
| **B**. Total number of Part-Time Equivalent Employees: |
| **C.** Total Number of Full-Time Equivalent Employees (FTE): (A + B) |

**Only Complete This Section If You Have Separate Entities with Multiple Tax Identification Numbers**

Is this group owned by another entity or entities? Yes or No

If **YES,** does the same person or set of people own more than 80 percent of each entity? Yes or No

If you answered yes to **both** questions, please reach out to your Account Representative as your combined groups FTE's may now reflect the definition of a large group,

**Group Contact Information (Please list all physical addresses for the business on page 2):**

**Mailing Address:**

| | | |
|---|---|---|
| Address 1: | | |
| Address 2: | | |
| City | State: | Zip: |
| County: | | |
| Phone number: | | |
| Email address: | | |

**Billing Address:**

| | | |
|---|---|---|
| Address 1: | | |
| Address 2: | | |
| City | State: | Zip: |
| County: | | |
| Phone number: | | |
| Email address: | | |

**Health Benefits Administrator Contact Information**

| | |
|---|---|
| **Main Contact** | Name: |
| **Billing Contact** | Name: |

**Broker Information:**

| |
|---|
| Broker or Agency Name: |

# RECERTIFICATION FORM FOR SMALL GROUP RENEWALS

**Physical Locations of the Business (Please list ALL locations, even if they are outside of NYS)**

**Location 1:**
Address 1:_____

Address 2:_____

City:_____ State:_____ Zip:_____

County:_____ Phone Number:_____

**Location 2:**
Address 1:_____

Address 2:_____

City:_____ State:_____ Zip:_____

County:_____ Phone Number:_____

**Location 3:**
Address 1:_____

Address 2:_____

City:_____ State:_____ Zip:_____

County:_____ Phone Number:_____

**Location 4:**
Address 1:_____

Address 2:_____

City:_____ State:_____ Zip:_____

County:_____ Phone Number:_____

**Location 5:**
Address 1:_____

Address 2:_____

City:_____ State:_____ Zip:_____

County:_____ Phone Number:_____

*If you have multiple locations please mark on the NYS 45 the office location that each employee, who is taking coverage, works from. If you need additional space please make a copy this page and submit it along with your other paperwork.

**10/29/15**