

June 19, 2019



Group Name: **Mandatory Poster Agency**

Group Number: **L0001596**

Renewal Effective Date: **December 1, 2019**

### Group Size Determination

[For information on how to complete this form, see reverse side]

Number of full-time employees	<b>38</b>
Number of full-time equivalent employees	<b>1</b>
Total number of full-time and full-time equivalent employees	<b>39</b>

### Additional Group Information

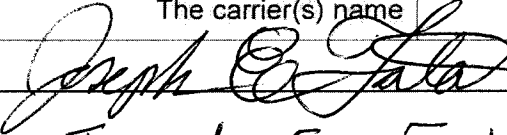
Company Legal Status (i.e., LLC, Corporation, Partnership, <u>S Corp</u> , Sole Prop, C Corp, etc.)	<b>S Corp.</b>
Please list names of all business owners/partners (if legal status is Corporation and the only enrollees in the health plan are owners, please provide a copy of your most recent Quarterly Wage Detail Report):	
Required number of hours worked weekly to be offered company sponsored healthcare	<b>30</b>
Total number of employees who are offered company sponsored healthcare	<b>10</b>
Number of employees offered company sponsored healthcare waiving due to having other coverage	<b>3</b>
Number of employees offered company sponsored healthcare waiving coverage for any other reason	<b>2</b>
Does your company offer coverage with any other carrier? (Yes/No)	<b>NO</b>
If "Yes", please provide the number of employees covered under other healthcare plan(s)	<b>N/A</b>
The carrier(s) name	<b>N/A</b>
Does your company offer retiree coverage? (Yes/No)	<b>NO</b>
If "Yes", please provide the number offered company sponsored retiree coverage	<b>N/A</b>
Please provide the number covered under company sponsored retiree coverage	<b>N/A</b>
The carrier(s) name	

Authorized Group Representative Signature

Printed Name

Title

Date

  
Joseph E. Fata  
President  
10-16-19

If you have questions regarding this form, please call your Account Manager, Jeanette Pung, at 517.364.8264.

Cc: Theodore Hollenbeck, Agent