Physicians Health Plan

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	38
Number of full-time equivalent employees	1
Total number of full-time **and** full-time equivalent employees	39

Additional Group Information

Company Legal Status (i.e., LLC, Corporation, Partnership, S Corp, Sole Prop, C Corp, etc.)	S Corp.
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	30
Total number of employees who are offered company sponsored healthcare	10
Number of employees offered company sponsored healthcare waiving due to having other coverage	3
Number of employees offered company sponsored healthcare waiving coverage for any other reason	2
Does your company offer coverage with any other carrier? (Yes/No)	No
If "Yes", please provide the number of employees covered under other healthcare plan(s)	N/A
The carrier(s) name	N/A
Does your company offer retiree coverage? (Yes/No)	NO
If "Yes", please provide the number offered company sponsored retiree coverage	N/A
Please provide the number covered under company sponsored retiree coverage	N/A
The carrier(s) name	

Authorized Group Representative Signature Joseph E. Fata

Printed Name Joseph E. Fata

Title President

Date 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