



ATTN: Underwriting, MS 326
 PO Box 91130
 Seattle, WA 98111-9230
 Toll Free 1-888-344-5593

528 East Spokane Falls BLVD Suite 301 Spokane WA 99202

Group Name _____

Group Number _____

Renewal Month _____

Group Size Certification

In order for Asuris Northwest Health (Asuris) to issue coverage for a health plan to a small employer group, it is necessary for us to ask you to provide us with information so that we can comply with state and federal insurance regulations of determining your group's eligibility (*). **We're unable to proceed with your request for new or renewing healthcare insurance coverage without this information.**

(*) *Group eligibility is based on group size which is determined by the average count of the total number of employees who were on your group's payroll and those individuals that were employed by an affiliated company during the previous calendar year. Groups that were not in business during the previous calendar year would base their group size on the current calendar year. The term "employee" means any individual employed by an employer. Contracted 1099 individuals are not included.*

Please complete the following (do not use this form to make any changes to your current policy):

1. **Employee Count** - Please enter the **average number of employees that were employed during the previous calendar year (January – December)**. Your Employee Count should include employees from any affiliated company, business owners, corporate officers, full-time, part-time, partners, seasonal, union employees and employees that work outside the State of Washington. Your Employee Count should **not** include **contracted 1099** individuals.

2. **Is your company a subsidiary or affiliate of any other company?** No Yes (*)

(*) If yes, the employee count of your affiliated company must be included in question #1.

3. **Is your company headquartered outside of the state of Washington?** No Yes

Group Authorized Signature > _____ (No producer (agent) signatures)

Group Authorized Name > _____

Official Title > _____

Signature Date > _____

Please retain a copy for your records and return this form in the enclosed postage-paid envelope or fax to (206) 332-6203. Thank you!