Blue Cross Blue Shield Blue Care Network of Michigan

600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Group Attestation Form for 2015 Medical Loss Ratio Reporting Period (2014 employee count)

Customer name _____ Customer ID _____

Please provide the following information:

1. **Current company or group name:**

   _____

2. **Current mailing address: (location where rebate should be mailed, if applicable)**

   _____

3. **Contact name:** _____

4. **Employee count**. Please provide the average number of active (nonretiree) employees in your company on business days during the 2014 calendar year. Include full-time, part-time and seasonal workers whether or not they are eligible for health insurance benefits. To calculate this number:
   - For each month, add together the number of full-time, part-time and seasonal employees for each business day , then divide the result by the number of business days in the month
   - Add the average monthly employee counts together and divide by 12.
   - Round the average number up or down to the nearest whole number.

   In accordance with federal law and regulations, sole proprietors and their spouses should not be included in the employee count.

   2014 employee count _____

5. **Sole proprietor status:** Please check one of the following:

   ☐ I am not a sole proprietor (or a sole shareholder).

   ☐ I am a sole proprietor (or sole shareholder) and my employees are enrolled (with BCBSM, BCN or another carrier) in the medical health care coverage that I sponsor

   ☐ I am a sole proprietor (or sole shareholder) and my employees are *not* enrolled (with BCBSM, BCN or another carrier) in the medical health care coverage that I sponsor

6. **Group health plan type.** Your group health plan status will fall into one of the following three options. Please check the appropriate option. If you are an ERISA-exempt church plan (as described below) you must also choose one of the rebate distribution options:

   ☐ My **group's health plan is an employee benefit plan** established or maintained by an employer or an employee organization (such as a union) that provides medical, surgical or hospital care for participants or their dependents directly or through insurance reimbursement.

☐ My **group's health plan is a nonfederal government plan** established or maintained for employees by state government, political subdivision of state government, or any agency or instrument of any of these.

☐ My **group's health plan is an ERISA-exempt church plan** (a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches exempt from tax under section 501 of Title 26 (29 USC 10025 (33)(A)).

ERISA-exempt church plans rebate options. Please check one of the following:

☐ The plan agrees to use any rebate issued for the benefit of the group health plan subscribers in accordance with 45 CFR §158.242. By checking this box, any applicable rebate will be sent to the group. (Note: If we do not receive this attestation, federal law requires BCBSM and BCN to distribute any rebates directly to the enrollees of the group health plan covered by the policy during the MLR reporting year. Each enrollee will receive an equal share without regard to how much each enrollee actually paid toward premiums.)

☐ The plan does not agree to use any rebate issued for the benefit of the group health plan subscribers.

BCBSM or BCN will distribute any applicable rebates in good faith based on this attestation. BCBSM and BCN will be held harmless for any losses that result from action taken based on this group attestation.

I am authorized by _____, sponsor of the group health plan described above. I attest that the employee counts provided above and the group health plan information are complete and accurate.

Name (print): _____

Title: _____

Signature: _____

Date: _____

If you would like future forms sent to you by email, please provide your email address:

_____

Please return this form by June 19, 2015, in one of the following ways:

- Web: Fill out the form at **bcbsm.com/rbtsurvey**
- Fax to 1-877-325-7853
- Scan and email to acadatacollection@bcbsm.com
- Use the enclosed postage-paid envelope or mail to:
  MLR/Renewal Underwriting Certification – 514F
  Blue Cross Blue Shield of Michigan
  600 E. Lafayette
  Detroit, MI 48226-9942
- Questions still? Call 1-855-269-9890