



Eligibility Certification Form

Employer Name: _____ Group Number: _____

Employer Address: _____

This Eligibility Certification Form and your most recent state wage and tax report will be used by HumanaDental to determine if your company and employees satisfy your plan's participation and eligibility requirements.

Employee Name:

Please list below all individuals who meet the following conditions, regardless of whether they are to be considered for coverage under your group plan

- Not listed on your most recent state wage and tax report, AND
 - Actively working for you OR
 - Not working, but currently covered on your group plan for any reason (i.e. state or federal continuation, disability, etc.)

Status Code:

Please use the following letter codes to indicate status

- SP** Sole proprietor (maximum of one person from this category may be eligible for coverage; must also be employed full time at this company)
- PAR** Partner or other owner (not a sole proprietor)
- FT** Full-time (working 30 or more hours per week, or as designated on your employer group application)
- PT** Part-time
- TM** Temporary or seasonal employee (working less than 48 weeks per year)
- TD** Totally disabled
- RE** Retired employee
- CO** Covered through state or federal continuation of coverage (COBRA)
- DC** Dual choice – waiving due to coverage with another group plan offered by you. Name of insurance carrier required.
- WA** Waiving coverage due to other group coverage (i.e. spousal coverage). Name of insurance carrier required.
- OI** Waiving due to individual or other coverage.

How paid:

- H** Hourly
- S** Salary
- L** Leased
- O** Other (i.e. commissioned, contracted, etc.)
- NA** Not applicable (i.e. COBRA, retired, totally disabled, etc.)

Employee Name	Date of Employment	Hours worked per week	Status Code	How Paid	Insurance carrier name, if status of DC or WA
1					
2					
3					
4					

Employer signature required on the back of this form

Employee Name	Date of Employment	Hours worked per week	Status Code	How Paid	Insurance carrier name, if status of DC or WA
5					
6					
7					
8					
9					
10					
11					
12					
13					

If additional space is needed, please attach additional pages.

A waiver form will be required for employees and their dependents that are waiving any of the coverages available under your plan.

- **I hereby certify that I have read this document and that the information provided is accurate and complete.**
- **I certify that all employees actively working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.**
- **I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and participation requirements are met at all times coverage is provided by HumanaDental (i.e. Wage and Tax form, Taxpayer I.D. numbers, W-2 forms, etc.)**
- **I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate any individual or group coverage or result in an increase in premium.**

Signature of Employer: _____ Date: _____

Print Name of Employer: _____ Title: _____