



Certification Required for CMS Section 111 Reporting - Minnesota

In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we are required to verify your employer group size annually. This mandatory verification provides us with the necessary data to report Medicare Secondary Payer information to the Centers for Medicare and Medicaid Services (CMS). This information also allows us to determine whether your group is considered a large or small group under Affordable Care Act regulations and accurately apply state and federal regulations as they relate to your group. Failure to accurately respond may result in penalties imposed by the federal government.

The information below must be completed and returned to Quartz by your renewal date in order to renew your plan. Please email the completed form to CMSSurvey@QuartzBenefits.com or fax it to (608) 471-4395. **Failure to return this information may result in a delay of your renewal or termination of your plan.** If you have any questions regarding this certification, **please contact your Account Manager at (800) 926-8227.**

- 1) Please provide the county in which your company is primarily located within the Quartz Service Area (i.e., Filmore, Houston, Olmsted, Winona): _____
- 2) Please list your company's Federal Employer Identification Number (Tax ID): *Include any subsidiaries and their Tax IDs, if applicable.*

List Company Name and Subsidiary Name(s)

Tax ID Number(s)

- 3) Is this a Multi-Employer Plan: Yes No
A multi-employer plan exists when two or more employers are sponsors or contributors to a multi-employer plan and at least one of the employers has 20 or more full and / or part-time employees. For example, company ABC and company DEF purchase health insurance coverage together under the DEF company name.
- 4) Enter the average number of employees working at least 20 hours per week on business days during the preceding calendar year, excluding employees whose health coverage is determined by a collective bargaining agreement, and excluding individuals working on a temporary, seasonal or substitute basis.* The number of employees should not include retirees and disabled former employees required to be covered. (include all locations):

**Collective Bargaining Agreement: If the group insured is a collective bargaining unit, only count employees who are part of the collective bargaining unit. Do not count other employees in the company.*

5) Did your company employ 100 or more employees (including full, part-time and seasonal) for 50 percent or more of your business days in the preceding calendar year?

- Yes: skip questions 6 and 7
- No: go to question 6

6) Did your company employ 20 or more employees (including full, part-time and seasonal) for more than 20 weeks in the preceding calendar year? (Note: 20 weeks do not have to be consecutive.)

- Yes: go to question 7
- No: skip question 7

7) Please indicate the date your company first had 20 or more employees (including full, part-time and seasonal) for more than 20 weeks in the preceding calendar year:

_____ (Month / Day)

**If your company has always had more than 20 employees, please use 01/01 as your response.*

Please provide the average number of employees that your company employed for the 20 weeks that your company had 20 or more employees:

CERTIFICATION

I HEREBY CERTIFY that I have read the above statement and to the best of my knowledge and belief, it is a true, correct and complete statement prepared in accordance with the applicable instructions.

I attest that I have the authority to sign on behalf of the company represented in this survey.

Signature: _____ Date: ___/___/___
(Officer / Owner or Group's Contact Signature Required)

Title: _____
(Please Print)

Company Name: _____