



# Employer Dental Certification (Groups Sold without Aetna Medical)

## Part 1 – Employer Information

Employer Name			
Employer Address	City	State	ZIP Code

## Part 2 – Employee Census by State - Provide a count, by state, for each category below for all employees.

State	Business Location ZIP Code	Full-Time	Part-Time	Retiree	Waiting Period	Total Employee
<b>Total Employees</b>						

## Part 3 – Dental Coverage Summary – Provide a count for each category below for all employees eligible for coverage.

1.	Total number of employees eligible for dental coverage. (Full-time only)	
2.	Total number of eligible employees applying/enrolling for dental benefits.	
3.	Total number of eligible employees waiving dental benefits coverage under the policy with coverage under their spouse’s coverage, other than individual coverage.	
4.	Total number of eligible employees waiving dental benefits coverage under the policy without coverage under a spouse’s coverage, other than individual coverage.	
5.	Total number of employees in an ineligible class or classes.	

How much are you contributing toward your employees’ dental benefits?

Employee:    0%    25%    50%    75%    Other \_\_\_\_ %

Dependent:    0%    25%    50%    75%    Other \_\_\_\_ %

## Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

For the purpose of Dental-Only sales “Small Employer” means, in connection with a Group Health Plan with respect to a Calendar Year and Plan Year, any person, firm, corporation, partnership or political subdivision that is actively engaged in business that:

- Employed an average of at least 3, but not more than 50, eligible employees on business days during the preceding Calendar Year, and
- Employed at least 3 employees on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is expected the employer will employ on business days in the current Calendar Year.

I certify that I qualify as a Small Employer.

**AND**

I certify that the information provided to Aetna is true and complete. I understand that if the above information is not complete or is not provided to Aetna in a timely manner, the dental benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void dental benefits coverage.

Signature of Officer, Partner or Owner	Title	Date
Print Name of Officer, Partner or Owner	Title	Date
Signature of Witness		Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a dental benefits plan is subject to criminal and civil penalties.