CHAMBER AND ASSOCIATION ATTESTATION FORM

ACCOUNT INFORMATION

Association/Chamber/Other Employer Organization Name: Ahrens Bar Association Marketplace

Business Name: _____ Tax ID #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone #: _____

Contact Email Address: _____ Fax #: _____

ACCOUNT SIZE VERIFICATION

Please check the appropriate box for the type of business entity:

☐ Account Size is **Small** — Total FTE (full-time equivalent) employees is **between 1 – 100** over previous calendar year

Note: Upon your upcoming effective date, you must have at least one common law employee who is not the sole owner of the business or the spouse of the sole owner of the business. **Provide a NYS-45-ATT-MN for each business along with this completed form.** For more information please visit: https://www.irs.gov/businesses/small-businesses-self-employed/employee-common-law-employee

For more information about calculating group size, visit: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faq

☐ Other, please explain: _____

Total # of Employees: _____ This number will be used for Medicare Secondary Payer (MSP) reporting purposes; not to determine account size.

I certify that all the information furnished on this form is current, true and complete to the best of my knowledge and I have read and agreed to this statement and that I have authority to sign on behalf of the abovenamed group. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation. I understand that Independent Health reserves the right to request additional information prior to approving my application for insurance. I understand that Independent Health may conduct an audit to ensure compliance with laws and regulations regarding sale of insurance to small groups, if there is an audit, we may be required to provide verification of the information submitted on this form.

Account Administrator's Signature: _____ Date: _____

Account Administrator's Name (print): _____ Title: _____

Please fax the completed form to (716) 250-7125 **OR** Email: Sharrita.Roberts@independenthealth.com
AND Ashley.Banks@independenthealth.com

If you have any questions or require additional information, please call (716) 631-5392 or 1-800-453-1910, option 4, to reach a member of our Sales Department.