univera HEALTHCARE

Annual Group Information Form (AGIF)

Please complete this form in its entirety. This form is required by New York State and failure to complete could result in your policy being cancelled.

Note: Underwriting may require additional documentation during review of the form, such as the most recently filed NYS-45 (or state equivalent).

Section 1: General Group Information

1. Group Number: _____ 2. Legal Entity Name: _____

3. Tax Identification Number (EIN/TIN): _____ 4. ZIP Code for Business Physical Address: _____

5. Does your business have any employees that are currently employed by a Professional Employer Organization (PEO) or leasing company and are covered as subscribers under this policy? ☐ Yes ☐ No

6. List Owners/Partners/Shareholders and Percentage of Ownership:
(Note: If there are more than four, please attach a separate listing.)

Name: _____ ____ % of Ownership Name: _____ ____ % of Ownership

Name: _____ ____ % of Ownership Name: _____ ____ % of Ownership

7. Commonly Owned or Related Businesses (if applicable):

_____

_____

Section 2: Group Size Regulatory Information *(Note: The value of questions 1&2 must be greater than 0.)*

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _____

2. Average number of employees and owners (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____

3. If your organization offers Univera Healthcare dental, enter total number of Dental eligible employees (including active employees and owners, retirees and individuals enrolled in COBRA): _____

Section 3: Contribution

1. Annual Employer Contribution to a single tier: Health Savings Account $ _____

   Health Reimbursement Account $ _____

2. If your organization offers Univera Healthcare dental, what is the monthly Employer Contribution to single tier dental? % _____

3. If your organization offers Univera Healthcare vision, what is the monthly Employer Contribution to single tier vision? % _____

The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Employer Authorized Representative Signature: _____ *Date:* _____

Print Name: _____ *Email Address:* _____

Univera Healthcare will submit reports with respect to the benefit plan, in the time and manner required under Section 204 of the Transparency Provisions of the CAA and/or related regulations and/or other authoritative guidance issued under the CAA, on behalf of the group relating to pharmacy benefits and drug costs.