

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

Group number: _____ Legal entity name: _____
(as listed on the NYS-45)

Tax identification number (EIN/TIN): _____ ZIP code for business physical address: _____

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

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

Commonly owned or related businesses (if applicable): _____

Section 2: Group size regulatory information (Note: The value of questions 1 and 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 CDPHP Delta Dental, enter total number of dental eligible employees (including active employees and owners, retirees and individuals enrolled in COBRA): _____

Section 3: Contribution

Annual employer contribution to a single tier:

Health savings account \$ _____ Health reimbursement account \$ _____

If your organization offers CDPHP 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: _____

CDPHP 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. In addition to the above, unless you notify CDPHP otherwise, you are authorizing CDPHP to complete and file with CMS a gag clause attestation on your behalf annually up until the date services are terminated as long as all of your benefits are entirely insured by CDPHP. You agree to CDPHP with any information that may be necessary in this respect.