

Requirement 1

- Have an Owner/Officer of the company sign the enclosed Employer Notification Response Required Letter.

Requirement 2

- Submit a copy of the most currently filed DE6 or Quarterly Wage Report (with no alterations) with a status code written next to each employee's name (See table below for status codes).

| Employee Description | Status Code | Eligible to enroll? |
|--|-----------------------------|--|
| 1099 (independent contractor) | 1099 | No |
| Enrolled or Enrolling | E | Yes – applications required for those not yet enrolled |
| Part-time | PT | No |
| Seasonal | S | No |
| Temporary | TP | No |
| Per Diem | PD | No |
| Union | U | No |
| Terminated | T | No |
| Waiving for individual policy or cost | WI | Yes |
| Waiving for other group coverage (spousal coverage or any government sponsored plan) | WG | Yes |
| In Waiting Period | WP (full-time date of hire) | Yes if waived for all employees |

Requirement 3

Are you submitting multiple DE6's? YES NO — If YES, complete the following:

- Verify that all groups enrolling have or will file taxes jointly.
- Verify each company enrolling shares a minimum of 50% common ownership.
- Verify each company enrolling has a related industry.
- Verify the total number of eligible employees for all groups combined does not exceed 50 (unless SB578 qualified).
- Complete the Common Ownership Statement (if not already on file).

Requirement 4

- Submit the group's current payroll ledger for newly hired employee(s) not listed on the DE6. Use the above status codes and write next to each employee's name.

| Company Name | | | |
|------------------------------|----------------------------------|-----------------------------|----------------------------------|
| Employee Names XXXXXXXXXX | Social Security # XXX-XX-XXXX | Employee Wages \$XXXX.XX | Employee Withholdings \$XX.XX |
| | | Wage Totals | Withholding Totals |
| | | | Run Date |

Requirement 5

Is your company contracted with a Professional Employer Organization (PEO)?

YES NO — If YES, complete the following:

- Submit a letter on company letterhead to explain PEO relationship (if not already on file).
- Submit 3 months of current payroll. Use the above status codes listed in Requirement 2 and write next to each employee's name.
- Submit current matching invoices from PEO. Salaries on invoices must correlate with salaries on payroll.

Should you have any questions, please feel free to contact our Recertification Department at (800) 558-8003.



Requirement 6

Owners/Partners enrolling and not listed on the DE6 or listed with less than the current minimum wage must provide the following items:

- Signed Owner/Partner Statement (enclosed)
- Owner/Partner's business tax filing (with no alterations) for the preceding calendar year as applicable to the company structure shown in the table below:

| Corporation | S Corporation | Partnership/ Limited Liability Partnership (LLP) | Limited Liability Company (LLC) | Sole Proprietorship | Clergy/ Non Profit |
|-------------------|----------------------------|--|------------------------------------|--|--|
| • 1120 Schedule E | • 1065 K-1 • 1120 S K-1 | • 1065 K-1 | • 1065 K-1 • LLC Form 568 | • 1040 Schedule C (only 1 owner can qualify) | • W2 and • 4361 Exemption from Self Employment Tax (if not already on file) |

Requirement 7

- Verify that all employees/owners enrolling are actively at work for 20+ or 30+ hours (as elected by the Employer for entire group) and earn at least a minimum wage salary as shown in the table below.

| Current Minimum Wage | X 20 or 30 hours | X 13 weeks (1 quarter) | = total salary required for eligibility |
|----------------------|------------------|------------------------|---|
| \$8.00 | X 20 | X 13 weeks | \$2,080.00 |
| \$8.00 | X 30 | X 13 weeks | \$3,120.00 |

Requirement 8

- Verify that 70% of eligible owners/employees have enrolled for medical coverage.

CALCULATE BELOW

| | | |
|----------|--|--|
| A | Provide total # of eligible employees/owners (enrolling or waiving) | |
| B | Provide total # of employees/owners waiving for other group coverage | |
| C | Provide total # of employees/owners enrolling for medical coverage | |

EMPLOYER CONTRIBUTION IS LESS THAN 100% OR A FIXED \$ AMOUNT

| | | | | | | | | | | | |
|-------|---|-------|---|-------|------|-------|---|-------|---|---------------|---|
| _____ | - | _____ | = | _____ | THEN | _____ | ÷ | _____ | = | _____ | % |
| A | | B | | X | | C | | X | | Participation | |

EMPLOYER CONTRIBUTION IS 100%

| | | | | | |
|-------|---|-------|---|---------------|---|
| _____ | ÷ | _____ | = | _____ | % |
| C | | A | | Participation | |

Requirement 9

Does your group have any out-of-state affiliations? YES NO - If YES, complete the following:

- Confirm group has a physical office located in California and is not a P.O. box or home residence.
- Confirm that 51+% of eligible employees/owners work or reside in California.
- Submit a current quarterly wage report for each state with employees (to include all employees in that state).

Requirement 10

Does your group also offer a Kaiser Permanente direct plan? YES NO - If YES, complete the following:

- Ensure there is a minimum of 5 employees/owners medically enrolled.
- Submit a copy of your current Kaiser bill if cancelling your Kaiser direct plan.
- Submit enrollment applications for all employees enrolling.

Should you have any questions, please feel free to contact our Recertification Department at (800) 558-8003.