univera HEALTHCARE

Group Size Information Form

Please complete this form in its entirety. The information on this form is required to verify group size information to confirm correct group classification. This form is required in conjunction with the Healthy NY Annual Recertification form.

Section 1: General Group Information

1. Group Number: _____

2. Legal Entity Name: _____

3. 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

Section 2: Group Size Regulatory Information

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: _____

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.

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.