Form LG23
10/20

Local Government Health Insurance Board
Affordable Care Act Full-Time Employee
Verification Form

Please use the information below to assist in completing the form:

A. Measurement Period
The period during which an employee's hours are tracked or measured by the unit. In order to be considered as an ACA full-time employee, the employee must have averaged 30+ hours per week or 130+ hours per month during the measurement period. The period can be between 3-12 months in duration.

- An employee is due credit for an hour of service for:
  - Each hour the employee is paid, or entitled to payment, for the performance of duties for the unit, and
  - Each hour the employee is paid, or entitled to payment for a period of time during which no duties are performed due to: vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence

B. Administrative Period
The period during which the employer calculates the amount of hours the employee worked during the measurement period.

C. Stability Period
The period during which the employee is either entitled to or not entitled to coverage based on the hours the employee averaged during the measurement period. The period must be at least six month and cannot be any shorter than the measurement period.

Name (First, Middle Initial, Last)		Social Security Number
Measurement Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year
Number of hours employee worked during Measurement Period: _____		
Administrative Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year
Stability Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year

TO BE COMPLETED BY EMPLOYER

This information is offered to assist units in complying with Affordable Care Act rules and regulations. However, all units subject to the ACA are solely responsible for complying with ACA rules and regulations. If the unit has any questions in regard to ACA compliance, the LGHIB recommends the unit confer with its attorney or other healthcare professional.

Local Government Unit Name: _____ **Unit Number:** _____

Signature of Benefit Administrator: _____ **Date:** _____