Form LG23
Reviewed 9/24

Local Gov Health and Wellness
Affordable Care Act Employee Verification Form

If your unit is subject to the ACA with 50 or more full-time employees (or full-time equivalents) and you believe that you must offer coverage to one of your temporary, part-time, seasonal, intermittent, or emergency employees, you must complete this form verifying that your unit is subject to the ACA, and the employee averages working more than 30 hours a week, or 130 hours a month, during the unit's measurement period.

Units with fewer than 50 full-time employees (including full-time equivalents) are not subject to the ACA employer shared responsibility provisions. All units subject to the ACA will be responsible for complying with all ACA employer shared responsibility provisions. Local Gov cannot provide guidance regarding a unit's compliance with the ACA.

An employee eligible pursuant to the ACA provisions must enroll in the LGHIP or submit a Declination of Coverage form with proof of acceptable other coverage.

Name (First, Middle Initial, Last)	Social Security Number

Average number of hours employee worked per week or per month during Measurement Period: _____

Measurement Period
This is the period you are checking the employee's hours. 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

Measurement Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year

Administrative Period
This is the time period during which the employer calculates the number of hours the employee worked during the measurement period and offers coverage to the employee. This period is generally 30 days and can be no longer than 90 days.

Administrative Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year

Stability Period
This is the time period during which the employee is covered by the insurance based on the hours they averaged during the measurement period. The period they are covered must be between 6-12 months and cannot be any shorter than the measurement period.

Stability Period	_____ (Start Date) Month/ Date/ Year	_____ (End Date) Month/ Date/ Year

TO BE COMPLETED BY EMPLOYER

I affirm the information on this form is true and correct. I also acknowledge that it is the unit's sole responsibility to comply with the Affordable Care Act Employer Shared Responsibility rules and regulations.

Unit Name: _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the Local Gov rules outlined in the Administrative Guide.

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