

# Group Size Attestation

## A. COMPANY INFORMATION

Company Name

Federal Tax ID#

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Office Phone # (XXX) XXX-XXXX

Ext.

E-mail Address

## B. GROUP SIZE ATTESTATION

For assistance in determining your group size and completing this form, please visit our **ACA Calculators** at [www.calchoice.com](http://www.calchoice.com).

To access this webpage click on ACA Calculators and then click on ACA Full Time Equivalent.

For additional information, please refer to [healthcare.gov](http://healthcare.gov) AB 1083, SB 125, your CPA or your legal counsel.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. In the previous calendar year, we employed \_\_\_\_\_ ACA Full-time equivalent employees.

## C. SIGNATURE

By signing this form, I acknowledge that this attestation may be subject to verification and agree to provide CaliforniaChoice® with any information necessary to do so. I affirm that I have authority to contract with CaliforniaChoice.

\_\_\_\_\_  
Authorized Group Contact (please print)\_\_\_\_\_  
Title (please print)\_\_\_\_\_  
Signature\_\_\_\_\_  
Date (MM/DD/YYYY)