Form LG23
Reviewed 8/23

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

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

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

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

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
Average number of hours employee worked per week or per month 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

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 LGHIB rules outlined in the Administrative Guide.

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