Pre-Renewal Form for New Hampshire Accounts

The following form has been provided to ensure that Harvard Pilgrim Health Care (HPHC) has the appropriate information to rate and process your renewal. **Renewal rates will not be released unless this form is returned to HPHC by**

Account Name: ______________________ **Tax ID #:** ______________________

Employer Contribution (not required for groups under 51 Eligible Emp) : ______________________

1. Total Number of Company Employees:
Please include the total number of employees who work for the company both in and out of the service area. Include all employees, even those not eligible for benefits. If your current number of employees is less than 20 but you employed more than 20 employees for 20 or more weeks at any time during the past two years, enter the largest number of employees in that period. The 20 weeks do not need to be consecutive. ☐

2. Total Number of Benefit Eligible Employees:
Please include everyone who actively works for the company both in and out of the service area including eligible full-time(1) and eligible part-time(2) employees as well as early retirees and COBRA participants, but excluding temporary employees. ☐

3. Total Number of Full time Equivalents:
Please enter the number of full time equivalents from the previous calendar year. Please refer to IRS guidelines (http://www.irs.gov/irb/2011-21_IRB/ar07.html#d0e150) on how total full time equivalents must be calculated. ☐

4. Total Number of Eligible Employees Subscribing with HPHC:
Please enter the number of total eligible employees, including early retirees on the active plan and COBRA participants subscribing with HPHC. ☐

5. Number of Employees Waiving Coverage:
Please enter the number of employees declining coverage due to coverage under another health plan as a spouse or dependent, Medicare, Veterans Program, or sponsored by a **second employer.** ☐

6. Number of Employees Declining Coverage:
Please enter the number of employees declining coverage due to coverage under another plan sponsored by this employer (if HPHC is not the sole source carrier(4)), or coverage purchased through a non-group plan. ☐

7 Number of Employees not wanting to participate on any health care benefits at this time:
Please enter the number of employees declining health insurance entirely. ☐

8. Check the box if *HPHC* is or will become your sole source carrier(4):
HPHC requires 75% participation of eligible employees on a stand-alone basis, and 37.5% participation as a dual option. Coverage is not guaranteed renewable if participation is not met. ☐

9. Does your company have any physical office locations outside of the state of New Hampshire?
If yes, please list street address, city, state and zip code for all location(s).

Y	N

(1) To be eligible for coverage, a full-time employee must work a normal work week of 30 hours or more.
(2) To be eligible for coverage, a part-time employee must work at least 15 hours per work week and be employed for a minimum of five months.
(3) A temporary employee is one who works on a full-time or part-time basis for a period of fewer than five months.
(4) A sole-source carrier means that the account offers only one company's health insurance products to its active employees.

HPHC Underwriting Policies

I agree to and understand that:

- Coverage is available on a guaranteed issue and guaranteed renewable basis, subject to satisfaction of HPHC Underwriting Guidelines;
- All HPHC rate quotes are subject to a review of final enrollment;
- HPHC reserves the right to audit to ensure adherence to underwriting guidelines and to re-rate based on audit findings;
- Coverage may be declined or modified if complete information is not received, and may be modified or declined upon receipt of complete information; and
- Employer will meet HPHC eligibility/participation requirements, which will be reviewed on an annual or an as needed basis.

I certify that all employer information and employer data reported on this renewal form is accurately represented.

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Signature, Employer or Authorized Broker/Consultant   Title   Date

Please return form to the attention of your Account Executive at: Harvard Pilgrim Health Care, 650 Elm Street, 2nd Floor, Suite 203, Manchester, NH 03101 or fax to Account Executive at: (603) 656-9560

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Census Information

Account Name: ______________________________ **HPHC Account #:** ______________________

For a sole-source quote, please provide a census of all active employees who will participate in HPHC benefits, including those on COBRA and excluding employees who have waived coverage.

Indicate Type of Coverage

Date of Birth mm/dd/yyyy	Individual	Dual	Employee/Child(ren)	Family
Ex.: 05/21/1960				*X*

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This information refers to products and services offered by Harvard Pilgrim Health Care and its affiliates,
Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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