New Hampshire Pre-Renewal Form

Please answer the following questions to determine if the account meets Small Group Underwriting Guidelines for Harvard Pilgrim Health Care. If you have questions, contact your Harvard Pilgrim Account Executive.

1.	**Account Name**	
2.	**Corp #**	
3.	**Employer Tax ID Number** Please enter the 9 digit Tax ID for this account.	
4.	**Is your business incorporated OR are you a sole proprietor or S corporation that regularly employs at least one individual that is not an owner and/or the spouse of an owner?** Please select one: Yes or No	
5.	**Total Number of Full time Equivalents** Please enter the number of full time equivalents from the previous calendar year. Please refer to IRS guidelines (Internal Revenue Bulletin: 2011-21 I) on how total full-time equivalents must be calculated. An FTE Calculator can be found on our website to help count FTEs (http://www.harvardpilgrim.org/FTEcalculator).	
6.	**Total Number of Employees** Please include the total number of employees who work for the company both in and out of 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.	
7.	**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 and eligible part-time employees as well as early retirees and COBRA participants but excluding temporary employees. (1) To be eligible for coverage, a full-time employee must work a normal work week of 30 hours or more and be employed for a minimum of five months. (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.	
8.	**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.	
9.	**Number of Employees Waiving Coverage** Please enter the number of eligible employees declining coverage due to coverage under another health plan as a spouse or dependent, Medicare, Veterans Program, or purchased subsidized coverage through state or federal exchange, or sponsored by a **second employer**.	
10.	**Number of Employees Waiving Coverage with Other Employer Sponsored Plan** 10a. Does your company currently offer coverage through another insurance carrier, or intend to during the next calendar year? Please select one: Yes, No	
	10b. If yes, 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), purchased coverage through state or federal exchange with no subsidy or coverage purchased through a non-group plan.	
11.	**Number of Employees Not Wanting to Participate on Any Health Care Benefits at this time** Please enter the number of eligible employees declining health insurance entirely.	
12.	**Number of Employees Living Outside the Service Area** Please enter the number of total eligible employees subscribing with HPHC who live outside the service area (MA, NH, ME, RI)	
13.	**Does your company have any physical office locations outside the state in which this HPHC policy is underwritten?**	
14.	**If yes, please list street address, city, state and zip code for all locations**	
15.	**Do you have a satellite location in Vermont?**	
16.	**Provide the number of subscribers who live in Vermont that work in the Vermont location**	
17.	**Number of Employees with Medicare A & B Coverage** For Employers with less than 20 Total Employees, please enter the number of active employees covered under both Medicare Parts A and B for each contract type	
	Individual	
	Dual	
	Parent/Child(ren)	
	Family	

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. Employers that do not meet the participation requirements may reapply for group coverage during the annual special open enrollment (November 15 - December 15) for an effective date of January 1. Participation rules will not be a factor in eligibility for group coverage during this special open enrollment period.

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

Signature, Employer or Authorized Broker/Consultant	Title	Date