Rhode Island Pre-Renewal Form

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. If renewal rates are not released, your account cannot renew with HPHC.

1. Account Name

2. Corp #

3. Employer Tax ID
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 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 | Internal Revenue Service (irs.gov) 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 Current Employees
Please enter the total number of current employees who received wages, tips, or other compensation (FT, PT, Seasonal, New Hires), anyone reported on the most recent federal form 941 or 944.

7. Total Number of Active Employees who are eligible for health insurance
Please include all full-time and part-time employees from all office locations who work the minimum number of hours required by your company to be eligible for health insurance. Do not include employees who are temporary, currently on COBRA or state continuation of coverage, or new hires who as of the renewal date have not yet met your waiting period.

8. Total Number of Eligible Employees Subscribing with HPHC
Please enter the number of total eligible employees including early retirees subscribing with HPHC. Do not include COBRA participants.

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, Mass Health, or purchased subsidized coverage through state or federal exchange, or sponsored by a second employer. Include active employees participating on HPHC's Medicare Enhance or Medicare Supplement plan.

10. Number of Employees Declining Coverage
Please enter the number of eligible 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).

14. Please confirm employer contribution policy meets the HPHC Underwriting Guidelines
50% or greater for individual and 33% or greater for dual parent/child(ren) or family coverage for full-time employees and proportional percentage for part-time employees.

15. Does your company have any physical office locations outside the state in which this HPHC policy is underwritten?

16. If yes, please list street address, city, state, and zip code for all locations

17. Do you have a satellite location in Vermont?

18. Provide the number of subscribers who live in Vermont that work in the Vermont location

19. 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:
(1) all HPHC rate quotes are subject to a review of final enrollment; (2) HPHC reserves the right to audit to ensure adherence to underwriting guidelines and re-rate based on audit findings; (3) Coverage may be declined/ modified if complete information is not received or upon receipt of complete information; (4) Employer will meet HPHC's eligibility/participation requirements, which will be reviewed on an annual or an as needed basis; and (5) Providing false information may result in cancellation or non-renewal of coverage or adjustment of rates.
Employers that do not meet the participation and/or contribution requirements may reapply for group coverage during the annual special open enrollment (November 15 - December 15) for an effective date of January 1. Participation and contribution rules will not be a factor in eligibility for group coverage during this special open enrollment period.
(2) By signing and submitting this information you are certifying that your company meets the definition of a Small Employer Group, and that all individuals in the group meet the requirements to be "eligible employees" as defined by R.I. Gen. Laws § 27-50-1 *et seq* and OHIC Regulation 11. HPHC reserves the right to audit this information on a yearly basis.

I certify that (1) all employer information and employer data reported on this renewal form is accurately represented and (2) the employer offers the health plan coverage to all full time employees living in Rhode Island and does not make a different percentage contribution to premium for full time employees living in Rhode Island based on such employees hourly or annual salary (except as allowed for employees covered under collective bargaining agreements or pursuant to legitimate employee longevity programs).

Signature, Employer or Authorized Broker/Consultant	Title	Date