

**Massachusetts Pre-Renewal Form**

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| 1. **Account Name**
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| 1. **Corp #**
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| 1. **Employer Tax ID Number**

Please enter the 9 digit Tax ID for this account. |  |
| 1. **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?**
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| 1. **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. An FTE Calculator can be found on our website to help count FTEs (http://www.harvardpilgrim.org/FTEcalculator). |  |
| 1. **Total Number of Company 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. |  |
| 1. **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.- To be eligible for coverage, a full-time employee must work a normal workweek of 30 hours or more and be hired for a period of at least five months.- To be eligible for coverage, a part-time employee must work at least 20 hours per workweek and be hired for a period of at least five months.- A temporary employee is one who works on a full-time or part-time basis for a period of fewer than five months.- If upon renewal an account that enrolled as a small business (50 or fewer eligible employees) last year has increased to over 50 eligibles, the account may still be eligible for small group health insurance. Please contact your Account Executive for details. |  |
| 1. **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. |  |
| 1. **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. |  |
| 1. **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. |  |
| 1. **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. |  |
| 1. **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. |  |
| 1. **Does your company have any physical office locations outside the state in which this HPHC policy is underwritten?**
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| 1. **If yes, please list street address, city, state and zip code for all locations**
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| 1. **Do you have a satellite location in Vermont?**
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| 1. **Provide the number of subscribers who live in Vermont that work in the Vermont location**
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| 1. **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. |  |
| 1. **Individual**
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| 1. **Dual**
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| 1. **Parent/Child(ren)**
 |  |
| 1. **Family**
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**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.

[ ]  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 Massachusetts and does not make a different percentage contribution to premium for full time employees living in Massachusetts 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