Harvard Pilgrim Health Care

a Point32Health company

Maine 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 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 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 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, eligible part-time and eligible early retirees as of the employer group's renewal rate effective date. Do not include COBRA participants or temporary employees.
- To be eligible for coverage, a full-time employee must work a normal work week of 30 hours or more and work more than 26 weeks per year.
- To be eligible for coverage, a part-time employee must work at least 10 hours per work week and work more than 26 weeks per year for an employer who has at least one other employee who works at least 20 hrs. per week or more
- A temporary employee is one who works on a full-time or part-time basis for a period of fewer than 26 weeks per year
- 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.

7a. Average Number of Benefit Eligible Employees in the prior calendar year
Used to determine group's rating category, i.e., small group or large group market. Average number of benefit eligibles during the prior calendar year should be determined using the same eligibility guidelines in question 7 above

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, Veteran's Program, purchased coverage through state or federal exchange, coverage purchased through a non-group plan or sponsored by a second employer.

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.

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. Average Monthly Percent of Premium covered by Employee/Member for Calendar Year
Please provide for RxDC require reporting purposes

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

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

16. Do you have a satellite location in Vermont?

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

18. 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:

- 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
- 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 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 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