

Firm Name: \_\_\_\_\_  
 Firm Number: \_\_\_\_\_  
 Renewal Date: \_\_\_\_\_  
 Account Manager: \_\_\_\_\_



## Pre-Renewal Certification Statement

*Thank you for taking the time to fill out this form. Anthem BCBSNH will use this information to ensure your compliance with Underwriting requirements. This information will also be used rate to and process your renewal. Renewal rates will not be released if this form is not returned and all members will be terminated at midnight on the last day of the month prior to your renewal date. Please return this form in the postage paid envelope we have provided or you can fax it to 603 665-5290 Attn: Underwriting.*

1A. Total number of full time employees: -----	<input style="width: 80%;" type="text"/>
1B. Total number of part time employees:-----	<input style="width: 80%;" type="text"/>
2. Total number of eligible employees on payroll that have met your probationary period:	<input style="width: 80%;" type="text"/>
3. Total number of eligible owners (if not included above), early retirees, cobra or state continuation participants who are covered under your group health insurance with Anthem:	<input style="width: 80%;" type="text"/>
4. Total number of <b>health eligible employees</b> Add box 2 + box 3:-----	<input style="width: 80%;" type="text"/>

**Waivers Vs. Declines** – an employee cannot be a waive and a decline. Please choose the appropriate box based on the descriptions below:

**Waiver** is a benefit eligible employee who has existing coverage such as Medicare or coverage as a spouse, subscriber or dependent on another health plan that is not offered by your company.

5. Total number of waivers -----

**Decline** is a benefit eligible employee who wishes to opt out of medical coverage or has an individual / Non-Group policy not offered by your company.

6. Total number of employees declining coverage -----

7. Subtract box 5 from box 4 - These are your **net eligible employees** -----

8. **Our records indicate the number of employees enrolled is** -----

9. Divide box 8 by box 7  
 This is your percentage of participation this number should be  $\geq 75\%$  -----

10. Do you offer your employees another health plan in addition to Anthem BCBS: Yes No

If Yes, what is the total number enrolled in this other plan: \_\_\_\_\_  
 Please identify other carrier's name: \_\_\_\_\_

11. I certify that this group is physically located in the state of New Hampshire and understand it is my responsibility to inform Anthem of any address changes. Yes No

12. Are any of your employees Vermont residents? Yes No If yes, how many? \_\_\_\_\_

13. Do you have any Vermont business locations? Yes No

*I certify that the foregoing information is true and complete to the best of my knowledge and belief.  
 I understand that false and/or incomplete responses or statements may result in termination of coverage.  
 Anthem BCBSNH reserves the right to request additional documentation in order to verify eligibility.*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_