

Firm Name: \_\_\_\_\_  
 Firm Number: \_\_\_\_\_ Renewal Date: \_\_\_\_\_  
 Account Executive: \_\_\_\_\_ Broker: \_\_\_\_\_



(Rev Sep/17)

## 2020 NH Group Market Verification Form

Thank you for your attention to this important form. Your action is required - **please complete and return this form within 10 days of receipt**. Failure to return a completed form will result in loss of coverage on midnight of the last day of the month prior to your renewal date. The Anthem BCBSNH Underwriting department requires this information to rate and process your renewal in the correct market segment.

**Please use calendar year 2019 and refer to the MVF instructions when completing this section.**

Please indicate the Total Number of Full Time Equivalents (FTE)  
 Refer to MVF Instruction sheet.

**Please use current employment data when completing the sections below.**

Please indicate the total number of Owners/Incorporators in the box to the left.  
 Please indicate how many owners/Incorporators are eligible for coverage \_\_\_\_\_  
 How many owners/Incorporators are enrolled \_\_\_\_\_

Please indicate the total number of employees within your employer group, include all employees regardless of fulltime, part-time or eligibility status. (Excluding owners/incorporators/spouses/domestic partners)

Please indicate total number of health eligible employees within your employer group (excluding owners/incorporators/spouses/domestic partners)

Please indicate the number of declines – these are eligible employees refusing to enroll in your group coverage and **do not** have other coverage such as coverage with a spouse, parent, domestic partner or an individual plan.

**Please indicate your market segment** (refer to MVF Instruction sheet for market segment definitions):

My company meets the definition of a

"small employer"     "large employer"     "individual market"

**Employer Contribution: (Required if you are a large employer only)**

Please indicate either the dollar amounts or percentage of contribution you provide to your employees

	Monthly Premium Contribution (\$)	Monthly Premium Contribution (%)	Monthly Cost Share Contribution towards deductibles & copays (\$)	Monthly Cost Share Contribution towards deductibles & copays (%)
Employer Share				
Employee Share				

Is your business physically located in New Hampshire?    Yes    No

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

Do you have any Vermont business locations?    Yes    No

Do you offer your employees another health plan in addition to Anthem?    Yes    No

If yes - who is the carrier and how many employees are enrolled with them \_\_\_\_\_

I understand that any person who knowingly presents, or causes to be presented, any false, incomplete or misleading information to an insurer which is material to an application for the issuance of an insurance policy or the rating of same, may be subject to criminal penalties under NH RSA 638:20. I certify the above information is true and complete to the best of my knowledge and belief. Anthem BCBSNH reserves the right to request additional documentation in order to verify eligibility.

Name:	Title:
Signature:	Date:
Email:	

# 2020 NH Group Market Verification Form Instructions

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**Please complete this section using calendar year 2019; calculating the total number Full Time Equivalents (FTE)**

**Step 1: Full Time Employee:** Calculate the number of employees who work at least 30 hours per week or 130 hours in a given month.

**Step 2:"Full Time Equivalency":** For any non-full time employee (see Step 1), add up the total hours worked during a given month for every non-full time employee and divide by 120.

For step 1 and 2 you must include actual hours worked and paid time off including fractions at this point.

**Step 3: Add Step 1 and Step 2**

**Step 4:** Repeat steps 1, 2 and 3 for every month.

**Step 5:** Add up the total for the year.

**Step 6:** Divide the total from Step 5 by 12

Drop all fractions and round down at this point and record result in designated FTE box.

Please refer to IRS guidelines for more clarification on how to calculate total full time equivalents.

[http://www.irs.gov/irb/2011-21\\_IRB/ar07.html#d0e150](http://www.irs.gov/irb/2011-21_IRB/ar07.html#d0e150) and  
<http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap43-sec4980H.pdf>

Please also refer to **IRS 414 (b), (c), (m) or (o)** for **common ownership** rules and regulations that could apply for group counting purposes.

## **Market Segment Definitions:**

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**Note:** The definitions below are used to determine the correct market segment for your renewal only. These definitions do not provide any guidance for the Employer Duty to Provide Coverage Mandate.

**SMALL EMPLOYER** - means a business or organization which employed on average 1 and up to 50 FTEs during the previous calendar year, excluding owners, their spouse(s) or domestic partner(s) and self-employed persons, using the FTE calculation as defined above.

**EXCEPTION:** C Corporations without eligible employees can renew in the small group market.

**LARGE EMPLOYER** - means a business or organization which employed on average 51 FTEs or more during the previous calendar year, excluding owners, their spouse or domestic partner and self-employed persons, using the FTE calculation as defined above.

**INDIVIDUAL MARKET** - means a business that does not have any eligible employees in addition to the owner(s), their spouses or domestic partners and is not a C Corporation.

Federal definition of a common law employee, excludes owners and their spouse or domestic partner. Your group coverage will not be eligible for renewal and you will have to obtain coverage via the individual market.