Mass General Brigham
Health Plan

PRE-RENEWAL CHECKLIST

1. GROUP INFORMATION

Company name: _____ SIC code: _____
Anniversary date: _____ Type of business: _____
Company physical address:
Street: _____
City: _____ State: _____ Zip: _____
Is the information above correct? ☐ yes ☐ no

If not, please make the changes below:
Company name: _____ SIC code: _____
Anniversary date: _____ Type of business: _____
Company physical address:
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

2. EMPLOYEES

Total number of employees (include part-time/seasonal): _____
Total number of benefit-eligible employees: _____
Total number of full-time equivalents: _____
Number of waivers: _____

3. EMPLOYER CONTRIBUTIONS

Individual: $_____** or_____% *Individual and Spouse: $_____** or_____%
Family: $_____** or_____%** *Individual and Dependent(s): $_____** or_____%

**All four contribution tiers must be completed for Merged Market accounts.*
***Minimum requirement is 50% for individual and 33% for all other tiers.*

4. OTHER CARRIERS, IF APPLICABLE

Carrier 1 name: _____

Carrier 1 contribution structure: _____

Carrier 2 name: _____

Carrier 2 contribution structure: _____

5. HEALTH REIMBURSEMENT ACCOUNT, IF APPLICABLE

HRA administrator: _____ Amount funded: $_____ or_____%

AUTHORIZED SIGNATURE

☐ By checking this box, I confirm the accuracy of the data reported above. Date: _____

Printed name: _____ Title: _____

Email address: _____

To ensure accurate renewal rates:
please return the completed form to your Mass General Brigham Health Plan Account Executive within two weeks.