Small group renewal decision form

PriorityHealth

Renewal group checklist

Use this checklist to expedite the processing of the renewal.

Send all materials to Priority Health in accordance with required 30 day lead time to ***PH-Renewals@priorityhealth.com*** or **616.975.8834**. If you have questions or need additional information, please call your independent insurance agent or the Priority Health Small Business department at **616.942.1820, option #4** or **800.471.2504**.

As a reminder, groups who do not submit a renewal decision at least 30 days prior to their renewal date will experience a delay in receiving their billing invoice.

- ☐ **Completed renewal decision form**
- ☐ **Copy of final proposal**

If applicable:

- ☐ **Copy of final dental proposal**
- ☐ **Copy of HealthEquity FSA checklist**
- ☐ **Copy of HRA Schedule of Reimbursement**

Renewal 01/01/2027;

GROUP INFORMATION

Group name *(must be full legal name as indicated on W9)*:	**Group number:**	**Renewal date:**
Innovate Solutions Inc.	PH-SG-987654	01/01/2027

Plan name: *(check one)*	**Plan design(s):** *Check all that apply. If renewing two plans, please list each below.*
☑ HMO ☐ PPO ☐ POS HMO - Priorit	☐ Renew current non-ACA plan ☐ Renew current ACA plan *(Note: Benefit changes may apply per ACA guidelines.)* ☐ Move to alternate ACA plan List plan name(s): PriorityHMO Gold 1500

Total # of employees:	**Total # of full-time/full-time equivalent employees:**	**Total eligible employees:**

Total # of employees enrolling:	**Total # of employees waiving:**

ELIGIBILITY REQUIREMENTS (If no changes, leave blank.)

New-hire waiting period:
(If there is more than one class of employee, please give the waiting period for each different class)

☐ Date of hire ☐ 30 days ☐ 60 days ☐ 90 days

OR

1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days

Full-time eligibility hours: _____

- Hours worked per week to be considered eligible for benefits
- Cannot be less than 17.5

Termination policy: ☐ Date of termination ☐ End of termination month

Layoff policy: ☐ Last day worked ☐ End of month ☐ 30 days ☐ 60 days ☐ 90 days

Disability policy: ☐ Last day worked ☐ End of month ☐ 30 days ☐ 60 days ☐ 90 days

Form continues on next page >

ADDITIONAL COVERAGE INFORMATION

Dependent eligiblity: ☐ End of the month dependent turns 26 ☐ End of the calendar year dependent turns 26

Are you offering domestic partner coverage?	**Are you offering early retiree coverage?**
☐ Limited (same gender)	☐ Yes
☐ Enhanced (same and/or opposite gender)	☐ No
☐ No	

HealthEquity

Would you like to add HealthEquity as the banking partner for the HSA plan? ☐ Yes ☐ No

Would you like to add HealthEquity Flexible Spending Account? ☐ Yes ☐ No (If yes, include HealthEquity FSA checklist)

SECTION 111

Based on today's date, did you have 20 or more employees for 20 or more calendar weeks during the previous or current calendar year?

Note: Includes full-time, part-time, intermittent, leased and/or seasonal employees excluding self-employed individuals.

☐ Yes — If you met this threshold during the previous year or current calendar year, please provide the date that this threshold was reached: _____ /_____ /_____

☐ No — Please enter today's date: _____ /_____ /_____

Did you have 100 or more employees during 50 percent of your business days during the previous calendar year?

Note: Includes full-time, part-time, intermittent, leased and/or seasonal employees excluding self-employed individuals.

☐ Yes — Enter 1/1 of the previous calendar year date: _____ /_____ /_____

☐ No — Please enter today's date: _____ /_____ /_____

PEDIATRIC DENTAL *(Only required when renewing with ACA-compliant plan)*

Small groups who are not purchasing coverage on the Health Insurance Marketplace must purchase pediatric dental benefits as part of Essential Health Benefits under health care reform. Even if you don't have children under the age of 19, you're required to purchase pediatric dental.

☐ Yes — I already have purchased pediatric dental coverage through a certified stand-alone dental carrier.

☐ No — I do not currently have pediatric dental coverage, but understand this is a requirement and certify my intent to purchase this coverage

☐ N/A, I am renewing my 2013 plan design, which does not require pediatric dental.

EMPLOYER CONTACTS *(If no changes leave blank)*

Group administration contact Jane Smith	**Phone** (555) 123-4567	**Email** jane.smith@innovatesolutions.com
Group billing contact Jane Smith	**Phone** (555) 123-4567	**Email** jane.smith@innovatesolutions.com
CEO/decision maker name Jane Smith		
Title HR Manager	**Phone** (555) 123-4567	**Email** jane.smith@innovatesolutions.com

SIGNATURES

Agent signature *(required)* Jane Smith	**Date** 11/15/2026
Employer signature *(optional)* Jane Smith	**Date** 11/15/2026

This form can be returned via email to:
PH-Renewals@priorityhealth.com *or by fax at* **616.975.8834.**