

# Pre-renewal Certification Form – REQUIRED

**Use this form as a cover sheet when you submit your information**

*I hereby certify that the information provided is accurate and complete.*

*I certify that all employees actively working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.*

*I certify the information provided can be substantiated by business documents.*

*I understand that wrapping is only allowed if my group purchases a PriorityHRA plan. Wrapping is defined as reimbursing coinsurance, copayment or deductible amounts with employer dollars directly, through an HRA, FSA or any other employer-funded medical reimbursement arrangement. This includes arrangements administered by Priority Health, a Third Party Administrator or internally by the employer group. Wrapping may also include an employer-sponsored supplemental plan that is offered with the intention of reimbursing deductibles, coinsurance or copayments. PriorityHSA cannot be paired with a traditional health FSA whether employee or employer-funded.*

*I understand that providing incomplete, inaccurate, false or late information may cause this Group coverage to be non-renewed.*

Group name

Group #

Sub#

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Group contact name and email address on file (if blank or incorrect, please update here)

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Signature of group's authorized representative (not the agent)

Date

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Print name of group's authorized representative

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Title of group's authorized representative

**“Employer Contribution” levels: *The amount the Employer contributes to Employee’s premiums:*** (Please indicate either the percentage or dollar amount.)

	Single	Double	Family
<b>Employer pays:</b>	_____	_____	_____
<b>Employee pays:</b>	_____	_____	_____