

**APPENDIX E. HMO FORM E**

**PRE-NOTIFICATION FORM  
REGARDING THE POTENTIAL COMPETITIVE IMPACT  
OF A PROPOSED MERGER OR ACQUISITION BY A  
NON-DOMICILIARY HMO DOING BUSINESS IN THIS  
STATE OR BY A DOMESTIC HMO**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Name of Other Person

Involved in Merger or  
Acquisition

Filed with the Insurance Department of

\_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_.

Name, title, address and telephone number of person completing this statement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ITEM 1. NAME AND ADDRESS**

State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

**ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES**

State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

**ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION**

State the nature and purpose of the proposed merger or acquisition.

**ITEM 4. NATURE OF BUSINESS**

State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.

**ITEM 5. MARKET AND MARKET SHARE**

State specifically what market and market share in each relevant HMO market and persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. For purposes of this question, market means direct written premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

**NOTE:** State Insurance Departments may additionally choose to make these calculations using their own data or data provided by the NAIC.