

APPENDIX E. HMO Form E

Figure 1

**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

Figure 2

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.