BlueCross BlueShield of Montana

REQUEST FOR PROPOSAL

(New Groups with 151+ Eligible Employees)

GROUP INFORMATION

Group Name:_____

Corporate Address: _____

Requested Effective Date:_____ Standard Industry Code:_____

Rate Proposal for (select all that apply):
☐ Medical ☐ Dental ☐ Vision ☐ Life

Quoting (select all that apply):
☐ Fully Insured, _____ Commission Amount
☐ Self Funded, _____ Commission Amount
☐ Administrative Only

Formal Proposal: ☐ Yes ☐ No

Match Benefits: ☐ Yes ☐ No

Geo Access: ☐ Yes ☐ No

Other Deductible Options: ☐ Yes ☐ No

Disruption Report: ☐ Yes ☐ No

Individual Stop Loss Level: _____

☐ Third Party Administrator: _____

☐ Contract Type (Select all that apply): ☐ 12/12 ☐ 12/15 ☐ 15/12 ☐ 18/12 ☐ 24/12

☐ Premium and Coverage Amounts for Specific and Aggregate Stop Loss: _____

☐ Claims Administration Fee Amount: _____

Is Group: Grandfathered? ☐ **OR** Non-grandfathered? ☐ Quote Due Date:_____

PRODUCER INFORMATION

Producer Name:_____ Phone No.: _____

Email: _____ Agency: _____

CURRENT COVERAGE INFORMATION

☐ Carrier: _____

☐ Detailed Benefit Summaries (quantity): _____

☐ Mark which was provided: ☐ Current Rates ☐ Renewal Rates ☐ or ASO Rate Equivalents

☐ Waiting Period for New Hires: ☐ DOH ☐ 30 ☐ 60 ☐ 90 day

☐ Employer Contribution Toward Coverage: _____$/% for Employee, and _____$/% for Dependents

☐ Two years of monthly claims experience (paid claims), exposures (number of employee's covered each month) and Premiums Paid (with Rx claims separated out from the Medical claims)

☐ Two years of large claims reports, including: (Please match same date span as monthly claims):
☐ Claim Amount ☐ Gender ☐ Enrollment Status (Employee, Employee's Spouse or Dependent)
☐ Diagnosis ☐ Prognosis

EMPLOYEE INFORMATION

Census Information:
Provide for all eligible employees [full, part-time, covered retirees and any individuals receiving benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)]. **Attach Excel spreadsheet with the following information:**

☐ Gender (M or F)

☐ DOB (mm/dd/yy) OR Age (in years)

☐ Home ZIP (5 digit)

☐ Covered by current plan? Yes/No
AND If more than one plan offered, show designation

☐ Enrollment Status (waived is considered OC or DC): EO, ES, EC, EF, CO, OC, DC, PT, WP

ADDITIONAL EMPLOYEE INFORMATION

While all items may not be available, please provide as much information as possible to ensure the most competitive rates for your account.

Total Employees: _____

Enrolled: _____ Waived: _____ COBRA: _____ Total Eligible: _____

Waiting Period: _____ Part-time: _____

Number in State: _____ Number out of State: _____

Number of HMO: _____ Number of PPO: _____

Please be advised, once we receive ALL REQUIRED ITEMS, we will forward to underwriting. Allow 10-12 business days to complete the proposal request. There are times when RFP volumes are higher than normal, which could result in a longer turnaround time.

PLEASE RETURN THIS DOCUMENT AND ADDRESS ALL QUESTIONS TO YOUR CORRESPONDING SALES EXECUTIVE EXECUTIVE:

TO: Jennifer_Buchanan@bcbsmt.com 406-437-6495

TO: Jeaneen_Campbell@bcbsmt.com 406-437-7303

TO: Peter_Gesuale@bcbsmt.com 406-437-6029

TO: William_Wagner@bcbsmt.com 406-437-5546