



GROUP INFORMATION

Group Name: _____

Corporate Address: _____

Requested Effective Date: _____ Standard Industry Code (SIC): _____

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 6-9 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:

TO: Courtney_Babcock@bcbsmt.com (406)437-6400

TO: Geary_Zale@bcbsmt.com (406)437-6376

TO: Lori_Roberts@bcbsmt.com (406)437-8831