



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Idaho Group Proposal Request Form

Groups 2-50 and 51-99

Please provide quote(s) for the following products:

- Regence Innova Regence Engage Regence Activate Regence HSA Healthplan 2.0
- Dental Vision Life / STD / LTD

Section 1 (complete Section 1 for all groups)

Company Name: _____ Requested Effective Date: _____

Primary Sales Contact Name: _____ Email Address: _____

Phone: _____ Fax: _____

Physical Address (Not a PO Box): _____

City: _____ State: _____ Zip: _____

Mailing Address (if different than physical address): _____

City: _____ State: _____ Zip: _____

Employer Tax ID # (EIN): _____ SIC Code / Industry Description: _____

Location of Company Headquarters: Idaho Other ***If 'other', please specify state:** _____

If company is headquartered outside of Idaho, please obtain and attach the Interplan Notification or Cede Agreement approval.

Other Locations of Business: (City, State & Number of employees in each location): _____

Eligibility:

of **total** employees (full & part time): _____ # of **eligible** employees: _____ # of **enrolling** employees: _____

Are all enrolling employees related to the owner? Yes No ***If yes**, additional documentation may be required

Is the group a Carve Out of a larger organization? Yes No ***If yes**, also complete Section 2 of this form

Minimum number of hours worked per week to be eligible for coverage: _____

Is the group COBRA eligible? Yes No

Please Note: Applications for existing COBRA enrollees must accompany request for firm quote

Are there qualified beneficiaries who are still within their COBRA election period (60 days from qualifying event) who have not yet elected COBRA coverage? Yes No

Will domestic partners be eligible for coverage? Yes No

Will a portion of the company's premium be paid through the Access to HealthCare Program? Yes No

Does the company self fund a portion of the deductible? Yes No

Agent Name: _____ **Agent Number:** _____

Employer Contribution:

Note: The minimum employer contribution is 50% towards the employee medical cost. There is no minimum employer contribution for dependent medical cost.

	Medical	Dental
Employee	_____ %	_____ %
Dependent	_____ %	_____ %

Current Insurance Plan(s):

Name of current medical carrier: _____

Current Renewal Date: _____ Original Effective Date: _____

Name of current dental carrier: _____

Does the company offer a Cafeteria Plan? Yes No

Has the group been advised of a rate increase? Yes No ***If yes, what is % of increase?** _____ %

Current Benefits:

Please note: Copy of current benefits is needed for most accurate rating for groups of 51-99 eligible employees

Trad PPO POS

Physician Co-payment: _____ Deductible: _____ Coinsurance: _____ Out-of-Pocket: _____

Prescription Drug: _____

Accidental Injury Maternity Vision Dental Life / STD / LTD

Section 2 (groups of 51-99 eligible employees or Carve out of larger organization, must also complete Section 2)

Has the group been insured with three or more carriers in the past five years? Yes No

Claims Experience: (Please provide details to **all** 'Yes' answers)

Yes No Has any employee been absent from work for more than five days during the past month due to illness or injury?
***If yes, please explain:**

Yes No Is any employee or dependent currently undergoing treatment for a Worker's Compensation injury, or had a Worker's Compensation claim exceeding \$5,000 in the past five years?

***If yes, please explain and give current status of person(s):**

Desired agent commission level? _____ % (3% commission is standard)