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PROPOSAL REQUEST FORM

Quote Type: ❑ Small group level funded ❑ Large group level funded ❑ Large group fully insured ❑ Large group self-insured

Requested effective date: **Requested due date:**

Employer Information:

Company name:	
Address (street, city, state, zip):	
County:	
Employer primary contact name, title & email:	
Description of business:	
Other in-state locations?	❑ YES ❑ NO If yes:
Other national locations?	❑ YES ❑ NO If yes:

Broker Information:

Name:	**Agency:**
Requested commission:	**Primary contact for proposal:**

Plan & Eligibility Information:

Current medical carrier:	**Years with current carrier**:	**Total employees:**
If HSA/HRA plans offered ❑ Embedded deductible ❑ Non-embedded deductible		**Total eligible employees:**
Number of hours per week to be eligible:		**Total enrolled employees:**
Will all employees be eligible? ❑ YES ❑ NO If no:		**Do employees receive cash back for waiving coverage?** ❑ YES ❑ NO If yes, how much per employee?:
Are early retirees eligible ❑ YES ❑ NO If yes:		**Does the group have Union employees?** ❑ YES ❑ NO Are they eligible for the medical coverage: ❑ YES ❑ NO
Are over 65 retirees eligible? ❑ YES ❑ NO If yes:		**Are the plans grandfathered?** ❑ YES ❑ NO
Is the employer subject to ERISA? ❑ YES ❑ NO		

Dental Information

Current dental carrier:	**Current funding type?** ❑ Fully insured ❑ Self-insured
Current Contribution: ❑ Voluntary ❑ Employer Sponsored	

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Employee and employer contribution

Please complete with monthly contributions for each plan ($ or %). OR attach a contribution page with the proposal request.

	EMPLOYER contribution **$ or %**	EMPLOYEE contribution **$ or %**	Annual EMPLOYER HRA Contribution	Annual EMPLOYER HSA Contribution	EMPLOYEE contribution **$ or %**	EMPLOYEE contribution **$ or %**	Annual EMPLOYER HRA Contribution	Annual EMPLOYER HSA Contribution
Enter plan name:	**Plan 1**				**Plan 2**			
Employee (EE)								
EE + Sp or EE + 1								
EE + Child(ren)								
EE + Family								
Enter plan name:	**Plan 3**				**Plan 4**			
Employee (EE)								
EE + Sp or EE + 1								
EE + Child(ren)								
EE + Family								

If contributions differ between employee classes or bargaining units, please explain or attach details:

Funding and rate tiers:

Current funding type	❑ Fully insured ❑ Self-funded ❑ Level Funded ❑ 105 fund/partial self-funding
Requested funding type	❑ Fully insured ❑ Self-funded ❑ Level Funded ❑ 105 fund/partial self-funding
Requested rate tiers:	❑ 2-tier ❑ 3-tier ❑ 4-tier (2-tier not available for Level Funded quote)

For self-funded quote:

	Current	**Requested**
Specific deductible		
Contract type (12/15, 15/12, paid)		
Aggregate coverage	❑ YES ❑ NO	❑ YES ❑ NO
Aggregate corridor		
Aggregating specific deductible?	❑ YES ❑ NO If yes:	
Any current lasers?	❑ YES ❑ NO If yes:	

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For level funded quotes:

	Current	Requested
Specific deductible		$30,000
Contract type (12/18, 15/12, paid)		12/18
Aggregate coverage	❑ YES ❑ NO	110% corridor
Requested plan design and network: (see SI EZ plan guide for details)		

Complete the wage and tax and COBRA sections below ONLY for small group level funded or health history groups

Employees and owners not accounted for on quarterly wage and detail report

Please use this space to account for employees and owners **NOT** included on the State Employer's Quarterly Wage and Detail report. Additional documentation may be required regarding owners.

Employee/owner name	Social security number*	Hire date	Termination date	# Of hours worked

Former employees enrolled with COBRA coverage

Please use this space to account for former employees covered by COBRA continuation. Indicate either the notification date if the individual is currently under COBRA or the cancellation date if an individual's COBRA coverage is terminating.

Former employee name	Social security number *	Notification date	Cobra termination date

**Employee's social security number is used for IRS tax reporting regarding the health plan. It does not have any impact on the application or enrollment.*

Additional information:

Internal use - Sales team:

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Documents must be carrier/source data reports

A **complete** submission is required in order to initiate the underwriting process.

Submit completed forms and all required documents including this checklist to: **LargeGrpSubmissions@healthpartners.com.**

Checklist of REQUIRED items:

Claims experience For groups with claims experience	**Small group level funded or Health history** For groups with 39 or less enrolled employees or group without claims experience
❑ Proposal Request Form	❑ Proposal Request Form
❑ 2 years of claims experience (most recent 24 months) with no overlap or gaps. Including: ❑ Enrollment information by month to match the experience period ❑ Large claims information (over $25K; include diagnosis and prognosis if available) for each reporting period.	❑ Employee Application – health history: for all eligible employees (applying and waiving coverage). Applications must be completed no earlier than 90 days from the effective date NOTE: Wisconsin Uniform Application can be used in place of the Employee Application for WI groups
❑ Current enrollment by tier and plan ❑ Current rates	❑ Wage and tax (most recent) for each location/ company indicating eligible (E) or ineligible (I) next to each employee
❑ Current census for all eligible employees (zip codes/states)	❑ Current bill: including names, rates, enrollment by tier and by plan
❑ Benefit summaries for all plans to match the claim reports	❑ Benefit summaries for all current plans
❑ Group Size Verification Form (if 50 or fewer employees enrolled; completed and signed by the employer)	❑ Group Size Verification Form (if 50 or fewer employees enrolled; completed and signed by the employer)
❑ Controlled Group Form (required if group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary	❑ Controlled Group form (required if group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary
❑ Renewal Documents with workup and rates (when available)	
❑ Employer Questionnaire; completed and signed by the employer	

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