Regence

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

New Group Proposal Request

Group size 2-50: Please select the product(s) you would like to have quoted and complete Section 1

☐ Quote All Plans ☐ Platinum ☐ Gold+ ☐ Gold ☐ Gold HSA ☐ Silver+ ☐ Silver ☐ Silver HSA ☐ Bronze+ ☐ Bronze HSA+ ☐ Bronze HSA ☐ EAP ☐ Dental ☐ Adult Vision

Group size 51-99: Please select the product(s) you would like to have quoted and complete Sections 1 and 2

☐ Innova ☐ HSA 2.0 ☐ Revive ☐ Employee Choice ☐ Dental ☐ Vision

Group size 100+: Please complete Sections 1 and 3

SECTION 1 - ALL GROUPS PLEASE COMPLETE THIS SECTION

General Group Information

Company Name			Requested Effective Date (mm/dd/yyyy)
Primary Sales Contact Name	E-mail Address Email address		
Phone Number (xxx) xxx-xxxx	Fax Number (xxx) xxx-xxxx		
Physical Address (Not a PO Box)	City	State State	ZIP Code xxxxx-xxxx
Mailing Address (if different than physical address)	City	State State	ZIP Code xxxxx-xxxx
Employer Tax ID Number (EIN)	SIC Code/Industry Description		

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

Other Locations of Business: (Please list City, State and Number of Employees in each location _____

_____

Please indicate Employer Contribution levels below:

	Medical	Dental
Employee	%	%
Dependent	%	%

Current Coverage

Name of Current Medical Carrier	
Current Renewal Date (mm/dd/yyyy)	Original Effective Date (mm/dd/yyyy)
Name of Current Dental Carrier	

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

Does the company self-fund a portion of the deductible? (i.e., Buy-Down Arrangement) ☐ Yes ☐ No

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

Eligibility		
Number of **total** employees (full & part time)	Number of **eligible** employees	Number of **enrolling** employees
Number of employees waiving for other qualifying coverage	Number of employees serving probation period	Number of employees declining coverage

Is the group a Carve Out of a larger organization? ☐ Yes ☐ No *If **yes**, also completed 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 for qualifying event) who have not yet elected COBRA coverage? ☐ Yes ☐ No

Agent Information		
Agent Name		Agent Number
Agency Contact Name	Phone Number (xxx) xxx-xxxx	E-mail Address Email address

51-99 Groups - Requested Agent Commission. Please Note: 3% is standard

Medical _____% Dental _____%

100+ (Fully Insured) Groups - Requested Agent Commission

Medical ☐ _____% ☐ PEPM $_____ ☐ PMPM $_____

Dental ☐ _____% ☐ PEPM $_____ ☐ PMPM $_____

100+ (Self Insured) Groups - Requested Agent Commission

Medical ☐ PEPM $_____ ☐ PMPM $_____

Dental ☐ PEPM $_____ ☐ PMPM $_____

SECTION 2 - GROUP SIZE 51-99 PLEASE COMPLETE THIS SECTION

Required for Quote

- ☐ Current and renewal benefit summary
- ☐ Current and renewal rates
- ☐ Detailed current census
- ☐ Current billing
- ☐ Regence Application for Enrollment (Group size 51-99)

Claims Experience (please provide details to "**Yes**" answers):

Has any employee been absent from work for more than five days during the past month due to illness or injury? ☐ Yes ☐ No

*If yes, please explain _____

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

*If yes, please explain _____

SECTION 3 - GROUP SIZE 100+ PLEASE COMPLETE THIS SECTION

Funding Type

☐ Fully Insured ☐ Self Insured

Required for Quote

- ☐ Detailed current census (minimum needed: gender, age or DOB, current enrollment status)
- ☐ Current and renewal benefit summary
- ☐ Effective date of last benefit change _____ (mm/dd/yyyy) (please also include prior benefit summary)
- ☐ Current and renewal rates
- ☐ 3 years claims experience by month
- ☐ 3 years large claim history
- ☐ Contract (ASO or Grandfathered status groups)