Regence

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 Employee Choice ☐ Regence HSA Healthplan 2.0 ☐ Regence Revive

☐ 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
Please Note: Not an option if purchasing Regence Revive.

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? (i.e. Buy-Down Arrangement) ☐ 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)