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Information that **MUST** be provided for rate finalization

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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Submission Prerequisites:

Large Groups & Level Funded Groups	**Claims Experience** • Fully insured • Self-funded	**Health History** • Fully insured without claims • Small group level funded • Large group level funded without claims	**CURV (GRX)** • Fully insured without claims • 25+ enrolled Not available on level funded quotes
P = REQUIRED for preliminary rates F = REQUIRED for final rates			
• Claims experience - most recent 24 months with no overlap or gaps	P		
• Contract enrollment – by month to match claims experience	P		
• Large claims information (over $25K, including diagnosis and prognosis if available) - for each reporting period	P		
• Current enrollment by tier & plan	P		
• Current rates	P		
• Current SBCs (benefit summaries) for all plans	P	F	F
• Renewal documents with workup and rates (required for CURV rating; preferred for claims experience and health history groups)			F
• Current census for all **eligible** employees (zip codes/states)	P		F
• Wage and tax (most recent) for each location/company indicating eligible or ineligible		F	
• Robin Employee Application – Health history for all eligible employees applying and waiving coverage (or OCI Universal application)		P	
• Current bill: including names, rates, enrollment by tier and by plan		F	F
• CURV census template for employees **taking** coverage: Last name, first name, zip code, birthdate, gender, contract tier with (employee/dependent)			P
• Employer Questionnaire (disclosure form)	F		F
• Group size verification form (if 50 or fewer employees enrolled; completed and signed by the employer)	F	F	F
• Controlled group form (required if groups has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary	F	F	F
• All missing waivers (health history groups)		F	

Note:

- Submit completed documents and forms to:
  - o **LargeGrpSubmissions@healthpartners.com or**
  - o **SmallGrpSubmissions@healthpartners.com**
- Items marked with a P are required to initiate the underwriting process.
- The decision to use CURV underwriting or health history questionnaires must be determined in advance.
- A completed proposal request form preferred but not required.
- All forms and plan guides are available in the Robin toolkit: HealthPartners.com/broker

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