Robin HealthPartners

Large Group Medical Proposal Request form

To be used for large groups with claims experience

Employer information

Requested Effective Date:		**Requested Due Date:**	
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 carrier:	**Years with current carrier**:	**If HSA/HRA plans offered:** ☐Embedded ded ☐Non-embedded ded
Total employees:	**Total eligible employees:**	**Total enrolled employees:**
Current funding type ☐Fully insured ☐Self-funded	**Requested funding type** ☐Fully insured ☐Self-funded	**105 or other Partial Self-funding?** ☐YES ☐NO If yes: _____
Do employees receive cash back for waiving coverage? ☐YES ☐NO If Yes: _____		
Are early retirees eligible? ☐YES ☐NO If yes:_____	**Are over 65 retirees eligible?** ☐YES ☐NO If yes:_____	
Is employer subject to ERISA? ☐YES ☐NO	**Are the plans grandfathered plans?** ☐YES ☐NO	
Does the group have Union employees? ☐YES ☐NO	**Will all employees be eligible?** ☐YES ☐NO If no:	
Current Dental carrier:	**Would you like a dental quote?** ☐YES ☐NO	

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

If contributions differ between employee classes, please explain:

Self-funded quote: (if applicable)

	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:_____	

Reason for marketing:

Additional information:

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Submit completed forms and all required documents including this checklist to:
LargeGrpSubmissions@HealthPartners.Com.

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

Checklist of REQUIRED items:

Documents must be carrier/source data reports

- ☐ 2 years of claims experience (most recent 24 months) with no overlap or gaps. The information **must** include:
  - ☐ Combined report for all plans
  - ☐ Separate reports by plan
  - ☐ Enrollment information by month to match the experience period
  - ☐ Large claims information (over $25K; include diagnosis and prognosis if possible) for each reporting period
- ☐ Current enrollment by tier and by plan if multiple plans are offered (Single/Family, EE/EE+1/Family, etc.)
- ☐ Current rates
- ☐ Renewal documents with workup and rates (when available)
- ☐ Benefit summaries (SBCs) for all plans to match the claims reports. Include SBCs for the current plan(s) and for plans included in prior year's claims experience. Self-insured requests should include Current SPDs or Certificates
- ☐ Current Census for all eligible employees (with zip codes and/or states listed)
- ☐ Group Size Verification form* (required if 50 or fewer employees are enrolled); completed and signed by the employer
- ☐ Controlled Group form* (required if the group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary)
- ☐ Employer Questionnaire* - completed and signed by the employer
- ☐ Partnership Questionnaire*(optional, but quotes given priority status and favorable financial consideration) - completed by the employer

*up-to-date forms available on the broker portal at HealthPartners.com

Internal use - Sales team:

Employer Questionnaire

Company Name: _____

Location of Site: _____

1. Are any employees not actively at work due to a disability or dependents over the age of 19 with a disability covered by your current medical plan or life plan?

   ☐ YES ☐ NO ☐ I have no information

   If yes, please provide the following information for all disabled employees (do not include names):

Check one	Date of disability	Medical reason for disability
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		

   If any person named above is being provided health care benefits by Workers' Compensation, please indicate (do not include names):

   _____

2. Are you aware of an employee or dependent covered by your group medical plan who is currently hospitalized?

   ☐ YES ☐ NO ☐ I have no information

   If yes, please provide the following information (do not include names):

Check one	Reason for hospitalization	Date of admission	Approximate cost, if known
☐ EMP ☐ DEP			
☐ EMP ☐ DEP			
☐ EMP ☐ DEP			
☐ EMP ☐ DEP			

3. Has any employee or dependent had total medical claims in excess of $25,000 in the past two years?

   ☐ YES ☐ NO ☐ I have no information

   If yes, please provide the following information (do not include names):

Check one	Reason for claims	Approximate cost, if known
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		
☐ EMP ☐ DEP		

4. Are you aware of any of the following health conditions for an employee or dependent covered by your medical plan?

Check one	Reason for claims
☐ YES ☐ NO	Awaiting a transplant (e.g. kidney, heart, lung, liver, bone marrow)
☐ YES ☐ NO	Has had a transplant
☐ YES ☐ NO	Newborn with major health problems (e.g. respirator dependent, low birth weight or residual impairment) under one year of age
☐ YES ☐ NO	Cancer in past five years
☐ YES ☐ NO	Serious accident (e.g. paralysis, comatose) in last two years
☐ YES ☐ NO	Other significant health problems (e.g. heart or circulatory problem, diabetes, hemophilia or HIV/AIDS)

If yes, please give details, such as actual medical diagnosis, date medical diagnosis was made regarding the medical condition. Do not include names.

5. Are you aware of any employee or dependent who has developed health conditions of a catastrophic nature or the severity of a condition has changed and wouldn't be reflected in the claims experience provided to HealthPartners?

If yes, please indicate which individuals and their condition (do not include names):

Employer Certification

As an employer representative, I certify that the information provided is complete and accurate to the best of current information available to the employer. The employer has conducted reasonable diligence in obtaining the information necessary to complete this certification and I am in a position to certify this on behalf of the employer.

Signature: _____ Name: _____

Title: _____ Date: _____

Please provide an estimate of the number of employees expected to enroll: _____

Partnership Questionnaire

Introduction

HealthPartners is an organization passionate about improving the health of the individuals and communities we serve. Through collaboration with you and your advisor, our vision is to create insightful solutions to improve the health of your employees and their dependents.

We believe companies who will invest a few minutes of their time to provide us some line of sight regarding their goals and objectives will also share our desire to build a collaborative solution together. We want to give these prospective partners the special consideration they deserve.

Preferred vs. Standard Proposal Process

This questionnaire is optional, but by answering the questions, your proposal request will be given priority status and will receive favorable financial consideration by our senior leadership team (e.g., better rate guarantees, discounted ancillary services, multiple year offer, or other financial consideration.)

Groups that do not answer the partnership questionnaire will be worked on in the order received and after all preferred groups are completed. Given our high RFP volume, especially during the second half of the year, we may not be able to meet your advisor's requested proposal deadline. Additionally, given the lack of information around your goals and objectives, no special financial consideration is available.

Please take a few moments and answer the following questions:

1. Please describe your organization's mission, vision, and values, and the value proposition your organization delivers to your customers.

2. What is your overall strategic direction as it relates to your health plan over the next 12-36 months?

3. What has worked well with your current plan and/or strategy? What hasn't worked?

4. What changes to your current benefits and/or strategy are you considering?

5. Please describe any tactical initiatives to increase employee engagement in their own health you have implemented (for example, implemented an incentive based, comprehensive wellness program, implemented marketing or communication campaigns promoting preventive screenings or other care improvement initiatives, educating employees on appropriate and cost effective place of care, etc.)

6. What does a collaborative partnership with your health plan and your advisor look like to you?

7. Describe the decision making process your organization uses with regard to your health plan benefits (timelines, key decision-makers, insurance committee involvement, etc.)

8. In addition to a competitive price, please describe the other key criteria you will evaluate when you make your decision, and how you will evaluate these.

9. Please list any other thoughts or comments you think would be helpful as we evaluate your group.

Thank you for your time and insight into how we can partner with you and your organization. We look forward to preparing a solution worthy of your consideration and sharing it with you and your advisor.