

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?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____		
Other national locations?	<input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Embedded ded <input type="checkbox"/> Non-embedded ded
Total employees:	Total eligible employees:	Total enrolled employees:
Current funding type <input type="checkbox"/> Fully insured <input type="checkbox"/> Self-funded	Requested funding type <input type="checkbox"/> Fully insured <input type="checkbox"/> Self-funded	105 or other Partial Self-funding? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____
Do employees receive cash back for waiving coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes: _____		
Are early retirees eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____	Are over 65 retirees eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____	
Is employer subject to ERISA? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are the plans grandfathered plans? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does the group have Union employees? <input type="checkbox"/> YES <input type="checkbox"/> NO	Will all employees be eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO If no: _____	
Current Dental carrier:	Would you like a dental quote? <input type="checkbox"/> YES <input type="checkbox"/> 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
	Plan 1	Plan 1	Plan 1	Plan 2	Plan 2	Plan 2
Enter plan name:						
Employee (EE)						
EE + Sp or EE + 1						
EE + Child(ren) (if applicable)						
EE + Family						
	Plan 3	Plan 3	Plan 3	Plan 4	Plan 4	Plan 4
Enter plan name:						
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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aggregate corridor		
Aggregating Specific Deductible?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____	
Any current lasers?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes: _____	

Reason for marketing:

Additional information:



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	
<input type="checkbox"/>	2 years of claims experience (most recent 24 months) with no overlap or gaps. The information must include: <input type="checkbox"/> Combined report for all plans <input type="checkbox"/> Separate reports by plan <input type="checkbox"/> Enrollment information by month to match the experience period <input type="checkbox"/> Large claims information (over \$25K; include diagnosis and prognosis if possible) for each reporting period
<input type="checkbox"/>	Current enrollment by tier and by plan if multiple plans are offered (Single/Family, EE/EE+1/Family, etc.)
<input type="checkbox"/>	Current rates
<input type="checkbox"/>	Renewal documents with workup and rates (when available)
<input type="checkbox"/>	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
<input type="checkbox"/>	Current Census for all eligible employees (with zip codes and/or states listed)
<input type="checkbox"/>	Group Size Verification form* (required if 50 or fewer employees are enrolled); completed and signed by the employer
<input type="checkbox"/>	Controlled Group form* (required if the group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary)
<input type="checkbox"/>	Employer Questionnaire* - completed and signed by the employer
<input type="checkbox"/>	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:

Plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc., a subsidiary of HealthPartners, Inc. Stop loss coverage is underwritten HealthPartners Insurance Company, a subsidiary of HealthPartners, Inc.

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
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> 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
<input type="checkbox"/> EMP <input type="checkbox"/> DEP			
<input type="checkbox"/> EMP <input type="checkbox"/> DEP			
<input type="checkbox"/> EMP <input type="checkbox"/> DEP			
<input type="checkbox"/> EMP <input type="checkbox"/> 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
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> DEP		
<input type="checkbox"/> EMP <input type="checkbox"/> 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
<input type="checkbox"/> YES <input type="checkbox"/> NO	Awaiting a transplant (e.g. kidney, heart, lung, liver, bone marrow)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Has had a transplant
<input type="checkbox"/> YES <input type="checkbox"/> NO	Newborn with major health problems (e.g. respirator dependent, low birth weight or residual impairment) under one year of age
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer in past five years
<input type="checkbox"/> YES <input type="checkbox"/> NO	Serious accident (e.g. paralysis, comatose) in last two years
<input type="checkbox"/> YES <input type="checkbox"/> 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 UnityPoint Health 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.