



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?	<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 medical carrier:	Years with current carrier:	Total employees:
If HSA/HRA plans offered <input type="checkbox"/> Embedded deductible <input type="checkbox"/> Non-embedded deductible		Total eligible employees:
Number of hours per week to be eligible:		Total enrolled employees:
Will all employees be eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO If no:		Do employees receive cash back for waiving coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how much per employee?:
Are early retirees eligible <input type="checkbox"/> YES <input type="checkbox"/> NO If yes:		Does the group have Union employees? <input type="checkbox"/> YES <input type="checkbox"/> NO Are they eligible for the medical coverage: <input type="checkbox"/> YES <input type="checkbox"/> NO
Are over 65 retirees eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes:		Are the plans grandfathered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the employer subject to ERISA? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Dental Information

Current dental carrier:	Current funding type? <input type="checkbox"/> Fully insured <input type="checkbox"/> Self-insured
Current Contribution: <input type="checkbox"/> Voluntary <input type="checkbox"/> Employer Sponsored	



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
	Plan 1				Plan 2			
Enter plan name:								
Employee (EE)								
EE + Sp or EE + 1								
EE + Child(ren)								
EE + Family								

	Plan 3				Plan 4			
Enter plan name:								
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	<input type="checkbox"/> Fully insured	<input type="checkbox"/> Self-funded	<input type="checkbox"/> Level Funded	<input type="checkbox"/> 105 fund/partial self-funding
Requested funding type	<input type="checkbox"/> Fully insured	<input type="checkbox"/> Self-funded	<input type="checkbox"/> Level Funded	<input type="checkbox"/> 105 fund/partial self-funding
Requested rate tiers:	<input type="checkbox"/> 2-tier <input type="checkbox"/> 3-tier <input type="checkbox"/> 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	<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:	



For level funded quotes:

	Current	Requested
Specific deductible		\$30,000
Contract type (12/18, 15/12, paid)		12/18
Aggregate coverage	<input type="checkbox"/> YES <input type="checkbox"/> 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:



Documents must be carrier/source data reports

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

Submit completed forms and all required documents including this checklist to: **LargeGrpSubmissions@healthpartners.com**.

Checklist of REQUIRED items:

Claims experience For groups with claims experience	Small group level funded or Health history For small group level funded and groups with 39 or less enrolled or a group without claims experience	Curv For groups without claims experience or for groups not completing health history applications. Not available on level funded quotes
<input type="checkbox"/> Proposal Request Form	<input type="checkbox"/> Proposal Request Form	<input type="checkbox"/> Proposal Request Form
<input type="checkbox"/> 2 years of claims experience (most recent 24 months) with no overlap or gaps. Including: <ul style="list-style-type: none"> <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 available) for each reporting period. 	<input type="checkbox"/> Employee Application – health history: for all eligible employees (applying and waiving coverage). Applications must be completed no earlier than 90 days from the effective date NOTE: Iowa Uniform application can be used in place of the Employee Application	<input type="checkbox"/> Current bill: including names, rates, enrollment by tier and by plan
<input type="checkbox"/> Current enrollment by tier and plan <input type="checkbox"/> Current rates	<input type="checkbox"/> Wage and tax (most recent) for each location/company indicating eligible (E) or ineligible (I) next to each employee	<input type="checkbox"/> Curv template for those taking coverage (Last name, first name, zip code, birthdate, gender, contract tier: employee/dependent)
<input type="checkbox"/> Current census for all eligible employees (zip codes/states)	<input type="checkbox"/> Current bill: including names, rates, enrollment by tier and by plan	<input type="checkbox"/> Current census for all eligible employees (zip codes/states) to help determine eligibility
<input type="checkbox"/> Benefit summaries for all plans to match the claim reports	<input type="checkbox"/> Benefit summaries for all current plans	<input type="checkbox"/> Benefit summaries for all current plans
<input type="checkbox"/> Group Size Verification Form (if 50 or fewer employees enrolled; completed and signed by the employer)	<input type="checkbox"/> Group Size Verification Form (if 50 or fewer employees enrolled; completed and signed by the employer)	<input type="checkbox"/> Group size verification form (if 50 or fewer employees enrolled; completed and signed by the employer)
<input type="checkbox"/> Controlled Group Form (required if group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary)	<input type="checkbox"/> Controlled Group form (required if group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary)	<input type="checkbox"/> Controlled Group form (required if group has ownership in multiple corporations or is part of a wholly owned or partially owned subsidiary)
<input type="checkbox"/> Renewal Documents with workup and rates (when available)		<input type="checkbox"/> Renewal Documents with workup and rates (when available)
<input type="checkbox"/> Employer Questionnaire; completed and signed by the employer		<input type="checkbox"/> Employer Questionnaire; completed and signed by the employer