

Large Group Proposal Request Form

51 + Employees

(The more complete the submission, the faster the turn around and competitiveness of the quote)

Group Name: _____

Address: (City, County, State) _____

Other Loc. _____

(# of EEs) (_____) (_____) (_____) (_____)

Nature of Business: _____ SIC Code: _____

Coverages (Check current)	Current Carrier	Renew Date	% Contrib	# of ees
Life/AD&D _____	_____	_____	_____	Active _____
Dep Life _____	_____	_____	_____	Retired _____
Medical _____	_____	_____	_____	COBRA _____
Dental _____	_____	_____	_____	Waivers _____
Vision _____	_____	_____	_____	Disabled _____
WI _____	_____	_____	_____	

	Enrollment		Current rates				Renewal Rates			
	# Ees	Medical	Rx	Dental	Vision	Medical	Rx	Dental	Vision	
Employee	_____	_____	_____	_____	_____	_____	_____	_____	_____	
EE/Child	_____	_____	_____	_____	_____	_____	_____	_____	_____	
EE/ Spouse	_____	_____	_____	_____	_____	_____	_____	_____	_____	
Family	_____	_____	_____	_____	_____	_____	_____	_____	_____	

Life _____ /\$1,000 AD&D _____ /\$1,000 Dependent Life _____ /Dep Unit _____ WI _____ /\$10 Ben.

Agent Name _____ AC Agent # _____ Telephone # _____

Due Date _____ Effective Date _____ Commission Requested _____

Are you the current agent of record? _____ e-mail: _____ Fax #: _____

For groups with 51 or more full time employees, you need to submit:

- | | |
|---|----------|
| Data to submit: | Enclosed |
| 1. Census (DOB, gender, coverage status, amt. of Life coverage, active, retired or COBRA) | _____ |
| 2. Details on any large claims or on-going, serious illnesses (Diag./Prog., \$ amount, disabled or back to work, age, gender). Have any of the large or serious illness claimants been removed from the plan? When? | _____ |
| 3. Copy of current plan design and any plan changes | _____ |
| 4. Outline of benefits to be quoted by line of coverage | _____ |
| 5. Details on any covered employees or dependents who during the past 5 years have received treatment for cancer, kidney diseases, heart disease, diabetes, Acquired Immune Deficiency Syndrome (AIDS), psychological, alcohol or drug disorders. | _____ |
| 6. Reason for carrier change. | _____ |
| 7. If effective date will be different than their current anniversary date, please explain. | _____ |
| 8. Do we need to match benefits? _____ Is employer satisfied with current benefits? _____ If not, please explain. | _____ |
| 9. Do they wish to change PPO Networks? _____ Which PPO Network? _____ | _____ |

Additional information required for 100+ employees.

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|--|-------|
| 10. Details on any large claim or on-going, serious illnesses (Diag./Prog., \$ amount, disabled or back to work age, gender). Have any of the large or serious illness claimants termed from the plan? When? | _____ |
| 11. 2-3 years month/month enrollment, premium and claims experience by line of coverage. | _____ |
| 12. Lag report and pended claims report for each plan year. | _____ |

LARGE GROUP (51+) INTERIM HSA PRODUCT OPTIONS FOR QUOTING

<u>MEDICAL & DRUG COVERAGE</u>	Check One	<u>ANCILLARY COVERAGES</u>	Check One
DEDUCTIBLE		DENTAL (Family ded. Is 3x) (Ortho to age 19)	
In Net/Out-of-Net		Plan 1: 100/80/50/50, 0/50/0/50 ded.	<input type="checkbox"/>
\$1,000/\$3,000	<input type="checkbox"/>	Plan 2: 80/80/50/50, 0/50/0/50 ded.	<input type="checkbox"/>
\$1,700/\$3,450 (Current MSA low deductible for 2-50)	<input type="checkbox"/>	Plan 3: 80/50/50/50, 0/50/0/50 ded	<input type="checkbox"/>
\$2,600/\$5,150 (Current MSA high deductible for 2-50)	<input type="checkbox"/>	Plan 4: 50/50/50/50, 0/50/0/50 ded.	<input type="checkbox"/>
\$3,500/\$7,000	<input type="checkbox"/>	No Ortho	<input type="checkbox"/>
\$5,000/\$10,000 (Only available with 100/80%)	<input type="checkbox"/>	Other: _____	
BENEFIT PERCENTAGE		VISION	
In Net/Out-of-Net		Eye Exam Plus only	<input type="checkbox"/>
100%/80%	<input type="checkbox"/>	Plan A: Co-Pay \$10/\$25, 12/24/24	<input type="checkbox"/>
90%/70%	<input type="checkbox"/>	Mod. Plan A: Co-Pay \$10/\$0, 24/24/24	<input type="checkbox"/>
80%/60%	<input type="checkbox"/>	Plan B: Co-Pay \$10/\$15, 12/12/24	<input type="checkbox"/>
NETWORK STOP LOSS		Mod. Plan B: Co-Pay \$10/\$0, 12/12/24	<input type="checkbox"/>
\$2,500	<input type="checkbox"/>	Plan C: Co-Pay \$10/\$0, 12/12/12	<input type="checkbox"/>
\$3,500	<input type="checkbox"/>	WEEKLY INCOME	
\$5,000	<input type="checkbox"/>	Plan 1: 1/8/13	<input type="checkbox"/>
PRESCRIPTION DRUGS (Will receive discount card)		Plan 2: 8/8/13	<input type="checkbox"/>
Subject to deductible and In-network benefit percentage	<input type="checkbox"/>	Plan 3: 15/15/13	<input type="checkbox"/>
Subject to deductible and Non-network benefit percentage	<input type="checkbox"/>	Plan 4: 1/8/26	<input type="checkbox"/>
Not Covered (Charges after discount not applied to deductible)	<input type="checkbox"/>	Plan 5: 8/8/26	<input type="checkbox"/>
PREVENTIVE CARE		Plan 6: 15/15/26	<input type="checkbox"/>
\$300 Subject to deductible and coinsurance	<input type="checkbox"/>	Flat Dollar Amount: \$ _____	
\$300 First dollar	<input type="checkbox"/>	Benefit % of Income: _____ %	
Not covered	<input type="checkbox"/>	LIFE/ADD&D (Minimum required is \$15,000)	
SUPPLEMENTAL ACCIDENT		Class 1: _____	
\$500	<input type="checkbox"/>	Class 2: _____	
\$1000	<input type="checkbox"/>	Class 3: _____	
None	<input type="checkbox"/>		

- | | | |
|--|------------------------------|-----------------------------|
| 1. 24 Hour Occupational Coverage? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Will this be a dual option plan of benefits?
If yes, the rates may change, depending on the demographics of plan selection at time of implementation. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. If there is an intent to co-exist with another carrier, we require a minimum of 75% participation of eligible employees, excluding those covered by their spouse's plan, part-time (not eligible), part of an excluded class of employees or those in the waiting period who are not eligible until after the effective date. | | |
| 4. Are you placing the fund Administration with American Community Mutual Insurance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Are you placing the fund Administration with Health Equity (AZ business only)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Is the employer contributing to the HSA fund?
If yes, please provide the monthly employer contribution levels:
Single \$ _____ Couple \$ _____ Parent \$ _____ Family \$ _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Is the employee required to contribute to the HSA fund?
Single \$ _____ Couple \$ _____ Parent \$ _____ Family \$ _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. How much of the High Deductible Health Plan premium does the employer pay?
Single \$ _____ Couple \$ _____ Parent \$ _____ Family \$ _____ | | |