BlueCross BlueShield of Oklahoma

REQUEST FOR PROPOSAL

New Business Checklist (151+ Eligible/Enrolled Employees)

DUE DATE:_____

EFFECTIVE DATE:_____

Commission: Fully Insured Self-Funded

Formal Proposal: ◯ Yes ◯ No Geo Access: ◯ Yes ◯ No

Disruption Report: ◯ Yes ◯ No Repricing Analysis: ◯ Yes ◯ No

GROUP INFORMATION

Group Name:_____

Corporate Address:_____

Standard Industry Code (SIC):_____

PRODUCER INFORMATION

Producer Name:_____ Phone No.:_____

Email:_____ Agency:_____

SELF-INSURED COVERAGE INFORMATION

☐ Third Party Administrator:_____

☐ Individual Stop Loss Level:_____

☐ Contract Type (Select all that apply): ☐ 12/12 ☐ 12/15 ☐ 15/12 ☐ 18/12 ☐ 24/12

☐ Premium and Coverage Amounts for Specific and Aggregate Stop Loss:_____

☐ Current/Renewal Admin Fees, Claim Factors, etc.:_____

☐ Additional ASO Information:_____

CURRENT COVERAGE INFORMATION

☐ Current Carrier: _____

☐ Current Benefits (provide detailed summaries):_____

☐ Provide the following: ☐ Current Rates ☐ Renewal Rates ☐ Premium Equivalents (for ASO)

☐ Waiting Period for New Hires: _____

☐ Employer Contribution Toward Coverage: _____$/% for Employee, and _____$/% for Dependents

☐ Most recent two years of monthly claims experience (paid claims with RX claims separated from Medical claims), exposures (number of employee's covered each month) and Premiums Paid

☐ Most recent two years of large claims reports (medical and RX) matching same date spans as monthly claims. The following information should be included:

☐ *Claim Amount ☐ Gender ☐ Enrollment Status (Employee, Spouse or Dependent)
☐ *Diagnosis ☐ Prognosis

*Minimum Required Information

Additional Information:

_____

_____

_____

_____

_____

_____

EMPLOYEE INFORMATION

Census Information:
Provide for all eligible employees [full, part-time, covered retirees and any individuals receiving benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)]. **Attach Excel spreadsheet with the following information:**

- ☐ Gender (M or F)
- ☐ DOB (mm/dd/yy) OR Age (in years)
- ☐ Home ZIP (5 digit)
- ☐ Covered by current plan? Yes/No
  AND If more than one plan offered, show designation
- ☐ Enrollment Status (waived is considered OC or DC): EO, ES, EC, EF, CO, OC, DC, PT, WP

ADDITIONAL EMPLOYEE INFORMATION

While all items may not be available, please provide as much information as possible to ensure the most competitive rates for your account.

Total Employees: _____

Enrolled: _____ Waived: _____ COBRA: _____ Total Eligible: _____

Waiting Period: _____ Part-time: _____

Number in State: _____ Number out of State: _____

Number of HMO: _____ Number of PPO: _____

Notes: _____

_____

_____

_____

_____

Please be advised, once we receive ALL REQUIRED ITEMS, we will forward to underwriting. Allow 8-10 business days to complete the proposal request. There are times when RFP volumes are higher than normal, which could result in a longer turnaround time.

FOR QUESTIONS, PLEASE CONTACT YOUR SALES EXECUTIVES:

Dena_Pride@bcbsok.com or Susan_Kent@bcbsok.com

6.17.2021
71856.1217