South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Associations Request for Proposal

Association Requesting Proposal - _____

Producer Requesting Proposal - _____

Producer Contact Information - _____

Phone E-Mail

Current Broker of Record - _____

Prospect Information

Prospect Company Name - _____

Tax Identification Number - _____

Type of Business - _____

Decision Maker Contact & Title - _____ _____

Name Title

Billing Contact Name - _____ _____

Name Title

_____ _____

E-Mail Phone Number

Address - _____ _____ _____ _____

Street City State Zip

_____ _____ _____ _____

PO Box City State Zip

Employer Premium Contribution - $_____or_____% $_____or_____%

Toward Single Cost Toward Dependent

Waiting Period for New Hires - _____

1st of Month Following DOH – 30 or 60 days

Current Carrier - _____

Carrier(s) Name(s) Last 2 Years - _____ | _____

Renewal Date - _____

Last renewal Increase or Decrease - _____%

Proposed Effective Date of AHP Proposal - _____

ALL ARE REQUIRED

Please attach

1) **Employee census (template attached) showing <u>all full-time eligible employees</u> of the employer**
   - **Name (last,first)**
   - **Zip code of home address (5 digit)**
   - **Date of birth**
   - **Gender**
   - **Employee or Dependent**
   - **Coverage type defined**
   - ***EE – Employee, ES – Employee/Spouse, EC – Employee/Child, FAM – Employee Family, WO – Waived-Other Coverage,***
   - ***WP – Waiting Period, NE – Not Eligible, RC – Refusing Coverage***
   - **List approved waivers for those refusing coverage**
   - ***MC – Medicare, MD – Medicaid, TRI – Tricare / VA, SC – Spousal Coverage***
2) **Current bill showing all covered employees and the monthly medical premiums**
3) **Current renewal, if quoting at the anniversary date.**
4) **A schedule of current medical, dental, life insurance and voluntary benefits**
5) **Groups of 10 or less must complete BCBS Personal Health Statement**

For employers with over 100 employees and all that are currently Fully Insured, Level-Funded or Self-Funded plans, please provide claims experience. (2 years claims experience and enrollment by month, plus the shock claims information for the same time period)

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Employer Supplemental Information

It is necessary for Blue Cross Blue Shield of South Carolina to obtain certain information in order to issue a proposal for group coverage. Please complete the following to the best of your knowledge.

		YES	NO
1.	Did any employee or dependent suffer a condition which resulted in a claim of $10,000 or more during the last 12 months?	___	___
2.	Are there any employees or dependents who have been or expect to be treated for a serious medical condition?	___	___
3.	Is any dependent child over age 19 incapable of self-support because of a physical or mental disability?	___	___
4.	How many employees and/or dependents are being covered under COBRA continuation? _____		
	To your knowledge, are there any serious medical problems on this group of COBRA continuation insureds?	___	___
	Is anyone presently covered under COBRA totally disabled?	___	___
5.	Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full-time?	___	___
6.	Are any employees or dependents presently disabled? *		
	* For an employee: he or she is absent from work due to injury or illness; * For a dependent: he or she is unable to perform the usual and customary activities of a person of like age and sex in good health.	___	___
7.	Carriers for the last five (5) years and length of time with each carrier:		

_____

_____

If any of the above questions were "YES", please explain below (write the question number and give details):

_____

_____

_____

Employer:_____ Date:_____

Signature of Applicant: _____ Title:_____

Signature of Agent or Record:_____