Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Request for Proposal

Date Submitted :	Date Proposal Needed:	Requested Effective Date:
☐ Medical	☐ Fully Insured ☐ Self-Funded SBFS ☐ Self-Funded Traditional	☐ PEX Quote ☐ Yes ☐ No
☐ Dental	☐ Group STD	☐ Voluntary STD
☐ Vision	☐ Group LTD	☐ Voluntary LTD
☐ Group Term Life and AD&D	☐ Voluntary Life and AD&D	

GROUP INFORMATION

Name of Firm/Group		BCBSLA Representative	
Address		Producer Name	
City State & Zip		Domiciled State	Office Headquarters State
Executive Contact/Group Leader Name and Title			Years in Business
Nature of Business	SIC Code (Required)	Recent Change of Ownership? ☐ Yes ☐ No Recent Change of Management? ☐ Yes ☐ No	

Is this group currently active with Blue Cross and Blue Shield of Louisiana? ☐ No ☐ Yes Group #

Are Retirees Covered for Health? ☐ Yes ☐ No Vision? ☐ Yes ☐ No Life? ☐ Yes ☐ No Dental? ☐ Yes ☐ No	Number of Retirees Covered Health: _____ Vision: _____ Dental: _____ Life: _____	A written copy of retirement policy must accompany a request for retiree coverage that includes the company's retiree definition.

Employer Contribution	Employee %		Dependent %		Employee $		Dependent $	
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
Medical								
Dental								
Vision								

NOTES

MEDICAL INFORMATION

MEDICAL LOSS RATIO (MLR)

The Patient Protection and Affordable Care Act (Affordable Care Act) includes a requirement that insurance companies report their medical loss ratio (MLR) to state and federal agencies, and pay rebates if certain MLR targets are not met. The calculation of the MLR is based, in part, on the size of the insurance companies' employer groups. Based on the information you provide, your group will be categorized as "small" or "large" for the purpose of applying the MLR requirements. This categorization will be used to determine whether your group will be eligible for rebates, if any.

Providing this information does not impact eligibility or participation requirements. Information needed to verify eligibility or participation will be requested separately.

What was the average number of employees employed by your company in the previous calendar year including owners?_____

In the case of an employer which was not in existence in the previous year, response should be based on the average number of employees that is reasonably expected to be employed on a business day in current year.

Please note: average must include all individuals owning or employed by the company and any affiliated company in the preceding calendar year, whether an employee was full-time, part-time and/or seasonal. Practically speaking, employees include all those issued a W-2, regardless of hours worked or enrollment in the health plan.

MEDICAL PLANS REQUESTED

☐ GroupCare PPO	Plan	Plan	Plan
	Plan	Plan	Plan
☐ BlueSaver	Plan	Plan	Plan
☐ Premier Blue	Plan	Plan	Plan
☐ HMO*	Plan	Plan	Plan
☐ Blue POS	Plan	Plan	Plan
☐ Community Blue	Plan	Plan	Plan
☐ BlueConnect	Plan	Plan	Plan
☐ Signature Blue	Plan	Plan	Plan

*Only available for large groups in accordance with PPACA regulations

MEDICAL INSURANCE HISTORY

Was group previously covered by BCBSLA? ☐ Yes Group # Date cancelled ☐ Not previously covered		Annual Renewal Date
Name of Current Insurer	☐ Fully-insured ☐ Self-funded	How Long
Name of Previous Insurer(s)	☐ Fully-insured ☐ Self-funded	How Long

Total # Employees on Payroll _____ Total # Eligible Employees _____ Total # Elsewhere Credits _____ Total # Employees Insured on Invoice _____	Current Fully Insured Commissions _____ Requested Fully Insured Commissions _____

MEDICAL DATA

CURRENT RATES	Plan	Plan	Plan
Employee Only			
Employee and Spouse			
Employee and Children			
Employee and Family			
RENEWAL RATES	**Plan**	**Plan**	**Plan**
Employee Only			
Employee and Spouse			
Employee and Children			
Employee and Family			

SELF FUNDED INFORMATION

DETAILS OF CURRENT COVERAGE

Current Carrier or TPA:	Provider Network:
If self-funded, current contract basis: ☐ Specific ☐ Aggregate	Current specific deductible amount:

Claims administration is being requested for the following categories and benefits to be considered for Aggregate and Specific excess risk:

	Aggregate	Specific		Aggregate	Specific
☐ Medical			☐ Dental		
☐ Prescription			☐ Vision		
☐ Other					

Total Number of Employees on Payroll _____ Total Number of Eligible Employees _____ Total Number of Employees on Invoice _____

Requested Commission $_____PMPM _____% of Stop Loss

Specific Excess Loss Insurance

Specific Deductible Amount Per Policy Period: $_____ $_____ $_____

Maximum Per Policy Period Per Covered Person (Excess of Specific Deductible) $ _____

Basis of Coverage:
- ☐ 12/12: Incurred and Paid within the Policy Period
- ☐ 15/12: Incurred within the Policy Period or 90 days immediately prior and Paid within the Policy Period*
  *Run-In Letter Needs to be Signed by the Group Leader and the Broker
- ☐ 12/15: Incurred within the Policy Period and Paid within the Policy Period or 90 days immediately after
- ☐ Other: _____

Coinsurance Factor (Reimbursement Percentage) _____ % (100% unless otherwise specified)

Aggregate Excess Loss Coverage

Margin (Excess of expected claims) _____% (125% unless otherwise specified)

Limit of Liability (Excess of Attachment Point) $_____

Basis of Coverage:
- ☐ 12/12: Incurred and Paid within the Policy Period
- ☐ 15/12: Incurred within the Policy Period or 90 days immediately prior and Paid within the Policy Period*
  *Run-In Letter Needs to be Signed by the Group Leader and the Broker
- ☐ 12/15: Incurred within the Policy Period and Paid within the Policy Period or 90 days immediately after
- ☐ Other: _____

Coinsurance Factor (Reimbursement Percentage) _____% (100% unless otherwise specified)

RATES AND FACTORS

Specific Rates	Aggregate Claims Factors
Current: Single	Current: Single
Family	Family
Renewal: Single	Renewal: Single
Family	Family

Current Aggregate Premium	$
Renewal Aggregate Premium	$
Current Administrative Fee	$
Renewal Administrative Fee	$
Current Broker Fee	$
Current of Stop Loss Commission	%

SMALL BUSINESS FUNDING SOLUTIONS (SBFS)

☐ Match Current Plans (if current BCBSLA Group) Requested Broker Commission $_____PEPM

☐ GroupCare PPO	Plan	Plan
☐ BlueSaver	Plan	Plan
☐ Premier Blue	Plan	Plan
☐ HMO	Plan	Plan
☐ Blue POS	Plan	Plan
☐ Community Blue	Plan	Plan
☐ BlueConnect	Plan	Plan
☐ Signature Blue	Plan	Plan

GROUP HEALTH QUESTIONNAIRE

Name of Group: _____

1. Were there any employees or dependents who incurred medical expenses of $10,000 or more during the last 12 month period? ☐ Yes ☐ No
2. Are there any physically handicapped dependents over age 19 covered by the current carrier? ☐ Yes ☐ No
3. Are there any COBRA enrollees? ☐ Yes ☐ No If yes, how many? _____
4. Are there any employees or dependents to be covered under the proposed coverage who currently have serious health problems? (for example, but not limited to: cancer, heart trouble, neuromuscular disorder, AIDS, hepatitis, liver disorder, kidney trouble, paralysis, lung disease, blood disorder or diabetes) ☐ Yes ☐ No
5. In the last 12 month period, has any employee been facility confined or received treatment on a recurring basis for Mental and Nervous and/or Substance Abuse? ☐ Yes ☐ No
6. Are there any maternity cases? ☐ Yes ☐ No If yes, how many? _____
7. Is there anyone on disability or on waiver of premium status? ☐ Yes ☐ No
8. If the answer to any of the above is yes, please give details including:

Name _____
Health Conditions (Dates) _____
Type of Treatment and Charges or Potential Charges _____

Name _____
Health Conditions (Dates) _____
Type of Treatment and Charges or Potential Charges _____

Name _____
Health Conditions (Dates) _____
Type of Treatment and Charges or Potential Charges _____

Name _____
Health Conditions (Dates) _____
Type of Treatment and Charges or Potential Charges _____

(Attach additional pages if necessary)

I understand and agree that this information is considered as part of the basis for issuing a group policy and establishment of premium rates. If a proposal of benefits and rates has already been issued, answers to, or changes in the answers to, the above questions will be cause for re-rating or cancellation of the group or withdrawal of any proposal.

_____ _____
Signature of Applicant (Employer)
(Need signature at time of enrollment)

Signature of Agent/Representative

_____ _____
Title of Applicant

Date

VISION INFORMATION

Plan customization not available under 1,000 eligible lives.

VISION INSURANCE HISTORY	☐ Employer Paid ☐ Contributory ☐ Voluntary
Requested Plan #:	Commission: ☐ 2-500 Standard 10% ☐ 500+ _____
LABI Quote: ☐ Yes ☐ No	Annual renewal date:
Name of Previous Carrier:	

VISION DATA	
CURRENT BENEFITS:	PROPOSED BENEFITS (1000+ ONLY):
Exam Copay:	Exam Copay:
Eyewear Copay:	Eyewear Copay:
Exam Frequency:	Exam Frequency:
Frame Frequency:	Frame Frequency:
Contact Lens Frequency:	Contact Lens Frequency:
Frame Allowance:	Frame Allowance:
Contact Lens Allowance:	Contact Lens Allowance:

Current Rates		Renewal Rates	
Employee Only		Employee Only	
Employee and Spouse		Employee and Spouse	
Employee and Children		Employee and Children	
Employee and Family		Employee and Family	

Experience data is required over 500 eligible lives.

Please attach for 500+ groups:

- Census should include number of eligible employees by state and zip codes. Retirees, if included, required for any size group.
- Group utilization with prior carrier (24 months)
- Current plan documents or SOB
- Current Invoice
- Commissions (If different from 10%)

-Notes-

Reminder: Beginning in 2016 Group Dental options are based on enrolled lives not MLR.

DENTAL INSURANCE HISTORY & DATA ☐ Employer Paid ☐ Contributory ☐ Voluntary

Current Carrier: _____ Years with Current Carrier:_____	Funding Type ☐ Fully Insured ☐ ASO	Total # Eligible Employees _____	Total # Expected Enrolled _____	Current Rates _____	Renewal Rates _____
Commission: 51-150 ☐ 0% ☐ 10% ☐ 15% ☐ 20% ☐ Commission: 150+ _____% Dual Option Offering: : ☐ Yes ☐ No		Employee Only Employee + Spouse Employee + Children Employee + Family	_____ _____ _____ _____	$_____ $_____ $_____ $_____	$_____ $_____ $_____ $_____

Out of Network Reimbursement Option (only available on 51+): ☐ 90th Percentile (Standard) ☐ Maximum Allowable Charge

USE BELOW FOR STANDARD PLAN REQUEST

☐ Plan A ☐ Plan B ☐ Plan B w/Ortho ☐ Plan C ☐ Plan C w/Ortho ☐ Implants (Not available with Plan A or Innovative Plans)

LABI: ☐ Plan B 85% ☐ Plan B Ortho 85% ☐ Plan C $75 ☐ Plan C Ortho $75		Smart Basics: Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Smart Stages: ☐
Annual Max: ☐ $1000 ☐ $1500 ☐ $2000 Available with or without Ortho	Annual Max: ☐$2500 Only available with $2000 Ortho Max and 51+ enrolled	Ortho Max: ☐ $1000 ☐ $1500 ☐ $2000 only available with $2500 Annual Max

USE BELOW FOR CUSTOM SINGLE OPTION PLAN (FOR 150+ ENROLLED ONLY) OR DUAL OPTION HIGH OPTION (51+)

Waiting Periods: ☐ Yes ☐ No	Basic:_____ months Major: _____ months Ortho:_____ months
Type 1 – Diagnostic/Preventive	Coinsurance: ☐ 100% ☐ Other _____
Type II – Basic	☐ Endodontics ☐ Periodontics Coinsurance: ☐ 50% ☐ 60% ☐ 80% ☐ Other _____%
Type III – Major	☐ Endodontics ☐ Periodontics Include Implants: ☐ Yes ☐ No Coinsurance: ☐ 50% ☐ 60% ☐ 80% ☐ Other _____%
Deductible (applies to Type II and Type III Services)	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ Other $_____
Family Maximum Deductible	☐ 3 ☐ Other _____
Annual Max	☐ $1000 ☐ $1500 ☐ $2000 ☐ $2500
Type IV: Orthodontic Maximum	☐ $1000 ☐ $1500 ☐ $2000 ☐ Adult ☐ None

USE BELOW FOR DUAL OPTION LOW OPTION

Waiting Periods: : ☐ Yes ☐ No	Basic:_____ months Major: _____ months Ortho:_____ months	
Type 1 – Diagnostic/Preventive	Coinsurance: ☐ 100% ☐ Other_____	
Type II – Basic	☐ Endodontics ☐ Periodontics Coinsurance: ☐ 50% ☐ 60% ☐ 80% ☐ Other_____%	
Type III – Major	☐ Endodontics ☐ Periodontics Include Implants: ☐ Yes ☐ No Coinsurance: ☐ 50% ☐ 60% ☐ 80% ☐ Other_____%	
Deductible (applies to Type II and Type III Services)	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ Other $_____	
Family Maximum Deductible	☐ 3 ☐ Other _____	
Annual Max	☐ $1000 ☐ $1500 ☐ $2000 ☐ $2500	
Type IV: Orthodontic Maximum	☐ $1000 ☐ $1500 ☐ $2000 ☐ Adult ☐ None	
Innovative Plan	SmartBasics: Plan 1 ☐ Plan 2 ☐ Plan 3 ☐	Smart Stages: ☐

Experience Data Requirements for groups with 150+ ENROLLED (please attach):
Current Summary plan description
Current plan design
Census data (include product elections, tier elections, 5-digit zip code & employment status, i.e. salaried, hourly, union, non-union, retirees)
Enrollment by month (prior 12 months or longer)
Premium by month (prior 12 months or longer)
Premium rates (current, renewal and prior years)
Claims History (by month)
Incumbent carrier network utilization

SNL Group Term Life - Commissions – 2 to 50 Lives

Group Term Life & AD&D	☐ 10% Graded*	☐ 10% Flat	☐ 12% Flat	☐ 15% Flat	☐ Other:
Voluntary Group Term Life & AD&D	☐ 15% Flat*				

*AXA Life and Disability Underwriting Requirements

ALL CASE SIZES REQUIRE: FILLABLE RFP AND CENSUS IN EXCEL FORMAT including gender and DOB. Additional requirements for disability requests or life with salary multiple: Salary, Job Title, Zip Codes, Retiree Content and Classes if applicable. If current coverage exists, need contracts, current plan design, rates, rate history and current invoice.

GTL: Over 500 **Enrolled** Lives: Premium vs. Claims for past 3 to 5 years broken out by month and year; detailed claimant listing, volume and enrollment by month, and any plan design changes and effective dates of change if available.

STD: Over 100 **Enrolled** Lives: Premium vs. Claims for past 2 to 3 years broken out by month and year. Provide enrollment and plan design history if available.

LTD: Over 500 **Eligible** Lives: Premium vs. Claims for past 3-5 years broken out by month and year. Provide enrollment, volume, plan design history, open claims report with valuation dates, age, date of DI, gender, reserves, monthly benefit, amount paid to date and nature of DI. Closed claim report should include valuation date, date of disability, date of claim termination and amount paid to date for claimant.

AXA Ancillary Commissions – 10+ Lives Disability – 51+ Group Term Life/AD&D

Voluntary Group Term Life & AD&D	☐ 15% Flat*				
Group Term Life & AD&D	☐ 15% Graded*	☐ 10% Flat	☐ 12% Flat	☐ 15% Flat	☐ Other:
Voluntary or Group Short Term Disability	☐ 10% Graded*	☐ 10% Flat	☐ 12% Flat	☐ 15% Flat	☐ Other:
Voluntary or Group Long Term Disability	☐ 15% Graded*	☐ 10% Flat	☐ 12% Flat	☐ 15% Flat	☐ Other:

*Standard Commission Scale

Definition of Earnings For Salary Based products:

Are Owners covered? ☐ Yes ☐ No If yes, do they file K-1? ☐ Yes ☐ No

☐ Standard (Salary only)

☐ Bonus ☐ Commission

AXA Producer Number: _____ (mandatory)

Contribution/Participation Data

Product	Employer Contribution%	Current Rate	Current Carrier
Life/AD&D			
Dependent Life			
Voluntary Life	0%		
Long Term Disability			
Voluntary LTD	0%		
Short Term Disability			
Voluntary STD	0%		

-Notes-

☐ Voluntary Group Term Life ☐ Add Voluntary AD&D

Eligibility: ☐ All Employees 30+ Hours Per Week ☐ Other _____		
Coverage Amount:	☐ Flat $10,000 Increments	☐ ____, _____, _____, ____, _____ x Salary (up to 5 times)
Voluntary Dependent Life	☐ Spouse	Child(ren) ☐ $ 5,000 ☐ $10,000
Guarantee Issue: Employee:_____	Spouse:_____	

☐ Group Term Life ☐ Add AD&D AXA Only: ☐ Add Travel Assistance Program

Eligibility: ☐ All Employees 30+ Hours Per Week ☐ Other:_____

Coverage Amount: Use this area when benefit is the same for all members		☐ x salary to a max of $		Guaranteed Issue $
		☐ $ Flat Amount		Guaranteed Issue $
☐ Classes: (Define) Max # of Classes based on case size: 2-9 Lives = 1 10-99 Lives = 3 100-299 Lives =5 300+ Lives = 6		Describe Class Below:		Describe Benefit Below:
	Class 1		Class 1	
	Class 2		Class 2	
	Class 3		Class 3	
	Class 4		Class 4	
	Class 5		Class 5	
	Class 6		Class 6	

Reduction Schedule:	☐ Standard (35% at 65; 50% at age 70) Other:			
Dependent Life:	☐ Spouse $10,000 ☐ Child $5,000	☐ Spouse $5,000 ☐ Child $2,500	LABI Only Spouse ☐ $5,000 Child ☐ $5,000	Spouse ☐ $10,000 Child ☐ $10,000

☐ Short Term Disability ☐ Add EAP ☐ FICA Match

Eligibility: ☐ All Employees 30+ Hours Per Week ☐ Other:_____

Benefit Percentage:	☐ 40%	☐ 50%	☐ 60%	☐ 66 2/3%	☐ Other %
Benefit Minimum:	☐ $25	☐ $50			
Weekly Benefit Maximum:	$				
Will this Replace Existing Coverage:	☐ Yes	☐ No			
Benefits Commence (Injury/Sickness)	☐ 1/8	☐ 8/8	☐ 15/15	☐ Other	
Benefit Duration (Weeks):	☐ 13	☐ 12	☐ 11	☐ Other	
	☐ 26	☐ 25	☐ 24	☐ Other	

If multiple options or classes are requested, please indicate in the space provided below:

☐ Voluntary Short Term Disability ☐ FICA Match

Eligibility: ☐ All Employees 30+ Hours Per Week ☐ Other:_____					
Benefit Percentage:	☐ 40%	☐ 50%	☐ 60%	☐ 66 2/3%	☐ Other
Benefit Minimum:	☐ $25	☐ $50			
Weekly Benefit Maximum:	$	Pre-Existing Conditions Limitation: ☐ 3/12	☐ Other		
Will this Replace Existing Coverage: ☐ Yes ☐ No					
Benefits Commence (Injury/Sickness)	☐ 1/8	☐ 8/8	☐ 15/15	☐ Other	
Benefit Duration (Weeks):	☐ 13	☐ 12	☐ 11	☐ Other	
	☐ 26	☐ 25	☐ 24	☐ Other	

If multiple options or classes are requested, please indicate in the space provided below:

☐ Long Term Disability ☐ Add EAP

Eligibility: ☐ All Employees 30+ Hours Per Week ☐ Other:_____						
Benefit Percentage:	☐ 40%	☐ 50%	☐ 60%	☐ 66 2/3%	☐ Other	
Monthly Benefit Maximum: $						
Will this Replace Existing Coverage? ☐ Yes ☐ No						
Elimination Period:	☐ 90 Days	☐ 120 Days	☐ 180 Days	☐ 365 Days		
Benefit Minimum:	☐ $50	☐ $100	☐ Greater of 10% or $100	☐ Other $		
Pre-Existing Conditions:	☐ 3/12	☐ 12/24	☐ 3/6/12	☐ 12/12	☐ 12/6/24	☐ Other
Benefit Duration:	☐ ADEA I/SSNRA	☐ ADEA 3 w/RBD	☐ ADEA 1 w/RBD	☐ 2 Year Graded	☐ ADEA 2 w/RBD	☐ 5 Year Graded
Definition of Disability:	☐ 24 Mo. Own Occupation/Any Occupation	☐ Other				
Social Security Offset:	☐ Primary	☐ Family				
Optional Riders:	☐ Activities of Daily Living (ADL)	☐ Cost of Living Adjustment (COLA)	☐ Other			
Mental Nervous and Substance Abuse:	☐ 12 Months/Lifetime	☐ 24 Months/Lifetime				
Survivor Benefit:	☐ 3 Months	☐ 6 Months				

If multiple options or classes are requested, please indicate in the space provided below:

☐ Voluntary Long Term Disability

Eligibility:	☐ All Employees 30+ Hours Per Week ☐ Other:_____
Benefit Percentage:	☐ 40% ☐ 50% ☐ 60% ☐ 66 2/3% ☐ Other %
Monthly Benefit Maximum:	$
Will this Replace Existing Coverage?	☐ Yes ☐ No
Elimination Period:	☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other
Benefit Minimum:	☐ $50 ☐ $100 ☐ Greater of 10% or $100 ☐ Other $
Pre-Existing Conditions:	☐ 3/12 ☐ 12/24 ☐ 3/6/12 ☐ 12/12 ☐ 12/6/24 ☐ Other
Benefit Duration:	☐ ADEA I/SSNRA ☐ ADEA 3 w/RBD ☐ ADEA 1 w/RBD ☐ 2 Year Graded ☐ ADEA 2 w/RBD ☐ 5 Year Graded
Definition of Disability:	☐ 24 Mo. Own Occupation/Any Occupation ☐ Other
Social Security Offset:	☐ Primary ☐ Family
Mental Nervous and Substance Abuse:	☐ 12 Months/Lifetime ☐ 24 Months/ Lifetime
Survivor Benefit:	☐ 3 Months ☐ 6 Months

If multiple options or classes are requested, please indicate in the space provided below: