



# Request for Proposal

**GROUP INFORMATION**

LEGAL NAME OF COMPANY

STREET ADDRESS OF HEADQUARTERS (STREET) (CITY) (STATE) (ZIP)

ARE ANY SUBSIDIARIES OR AFFILIATES TO BE INCLUDED?  YES  NO IF YES, NAME AND LOCATION OF EACH (CITY, STATE AND ZIP)

ARE ANY EMPLOYEES WORKING AT LOCATIONS OTHER THAN THOSE LISTED ABOVE?  YES  NO IF YES, LIST NUMBER OF EMPLOYEES AND LOCATION (CITY, STATE AND ZIP)

**NATURE OF BUSINESS** BE DESCRIPTIVE AND SPECIFIC STANDARD INDUSTRIAL CLASSIFICATION (SIC) (IF AVAILABLE)

SPECIAL COMMENTS:

**GROUP COVERAGE REQUESTED (check all that apply)**

- MULTI-OPTION HEALTH PLAN  DENTAL  BLUELINC'S HMO ONLY  GROUP TERM LIFE AD&D  DEPENDENT LIFE  SHORT TERM DISABILITY  LONG TERM DISABILITY\*  SECTION 125 PREMIUM ONLY  SECTION 125 FULL FLEX

\*IMPORTANT NOTE: For Long-Term disability quotes, please contact your assigned Blue Cross and Blue Shield of Oklahoma or Member Service Life Insurance Company Account Executive.

**EMPLOYER CONTRIBUTION PERCENTAGES (DOLLAR LEVEL OR % - MINIMUM 50% REQUIRED)**

HEALTH COVERAGE		TERM-LIFE COVERAGE	DEPENDENT LIFE COVERAGE	SHORT-TERM DISABILITY COVERAGE
Single Percentage	Dependent Percentage	Percentage	Percentage	Percentage

**ADDITIONAL INFORMATION**

TOTAL NUMBER OF EMPLOYEES WORKING 24 OR MORE HOURS PER WEEK AT THIS COMPANY	TOTAL NUMBER OF EMPLOYEES ENROLLED IN EMPLOYER'S SPONSORED HEALTH PLAN	TOTAL NUMBER OF EMPLOYEES ENROLLED IN EMPLOYER'S SPONSORED TERM LIFE PLAN
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WAITING PERIOD TO GET ON HEALTH PLAN FOR NEW HIRES (DAYS) WAITING PERIOD TO GET ON LIFE PLAN FOR NEW HIRES (DAYS) WILL THE WAITING PERIOD BE WAIVED AT INITIAL ENROLLMENT?  YES  NO **IMPORTANT NOTE:** If group has more than 100 employees and/or individuals other than those working 24 hours or more per week who are eligible for coverage, please see "special notes" section at end of this RFP.

**CURRENT HEALTH PLAN INFORMATION**

CURRENT HEALTH PLAN CARRIER

TYPE OF PLAN  HMO  PPO  MULTI-OPTION  OTHER (describe) ANNUAL DEDUCTIBLE  YES  NO DEDUCTIBLE AMOUNT IN-NETWORK OUT-OF-NETWORK

OFFICE VISIT COPAY  YES  NO IF YES, (please describe) COINSURANCE LEVEL IN-NETWORK OUT-OF-NETWORK

Rx CARD  YES  NO IF YES, (please describe) STOP-LOSS LIMIT (OUT-OF-POCKET MAX) IN-NETWORK OUT-OF-NETWORK

RATE INFORMATION IN-FORCE HEALTH PLAN		EMPLOYEE	EMPLOYEE & SPOUSE	EMPLOYEE CHILD(REN)	FAMILY
		CURRENT RATE			
	RENEWAL RATE				

**ADDITIONAL INFORMATION**

YOUR NAME

ADDRESS PHONE FAX ARE YOU A PRODUCER?  YES  NO

**CURRENT TERM LIFE AND SHORT-TERM DISABILITY INFORMATION**

CURRENT TERM LIFE CARRIER	CURRENT STD CARRIER
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CURRENT TERM LIFE BENEFITS (PLEASE DESCRIBE OR ATTACH DESCRIPTION)

CURRENT STD BENEFITS (PLEASE DESCRIBE OR ATTACH DESCRIPTION)

<i>PROPOSED BENEFITS</i>	<i>ELIGIBILITY</i>	<i>AMOUNT OF COVERAGE</i>
<b>GROUP TERM LIFE</b> ▶	<i>CLASS I</i>	
	<i>CLASS II</i>	
	<i>CLASS III</i>	

<b>DEPENDENT LIFE</b> ▶	<i>SPOUSE</i>	
	<i>CHILDREN</i>	

	<i>BENEFIT OPTION</i>	<i>AMOUNT OF COVERAGE</i>
<b>SHORT-TERM DISABILITY</b> ▶	DAYS ACCIDENT	% OF WEEKLY SALARY
	DAYS SICKNESS	\$ MAXIMUM BENEFIT
	DAYS HOSPITAL	
	WEEKS	

	<i>REDUCES BY</i>	<i>AT AGE</i>	<i>REDUCES BY</i>	<i>AT AGE</i>
<b>GROUP TERM LIFE/AD&amp;D</b> ▶	35%	65	_____ %	_____
	55%	70	_____ %	_____
<b>TERMINATION AND REDUCTION OF COVERAGE</b>	<input type="checkbox"/> ADEA 70%	75	<input type="checkbox"/> OTHER _____ %	_____
	80%	80	_____ %	_____

	<i>LIFE</i>	<i>AD&amp;D</i>	<i>DEPENDENT LIFE</i>	<i>STD</i>
<b>CURRENT RATES</b> ▶				

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED HEREIN IS COMPLETE AND TRUE. I UNDERSTAND THAT BLUE CROSS AND BLUE SHIELD OF OKLAHOMA RELIES ON THE INFORMATION PROVIDED IN THIS QUESTIONNAIRE AND RESERVES THE RIGHT TO RETROACTIVELY CANCEL THE GROUPS POLICY IF FRAUDULENT OR INCOMPLETE INFORMATION IS PROVIDED TO BLUE CROSS AND BLUE SHIELD OF OKLAHOMA.

AUTHORIZED SIGNATURE _____	DATE _____	PRODUCER SIGNATURE _____	DATE _____
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