Minnesota Health Care Consortium – Request for Proposal Information

Name of Group: _____

Decision Maker: _____Title:_____

Phone Number: _____ Email Address: _____

Address: _____

School☐ City☐ County ☐ Other Government Agency☐ (specify and attach ERISA Exempt Form)

Requested Effective Date: _____ Proposal Due Date: _____

History with Minnesota Healthcare Consortium/Service Cooperatives/Blue Cross: Y☐ or N☐
If yes please describe dates and region: _____

Name of Agent /Agency: _____ Current AOR: Y☐ or N☐

Commission: Please specify per contract per month or on a percentage basis:

PCPM: _____ %: _____ Included on Proposal or Billed Separately?: _____

Group's Current Carrier: _____

Prior Carrier (if less than 2 years): _____

Fully Insured or Self Insured? _____

Total Eligible Lives: _____ Are early retirees eligible?: Y☐ or N☐

Total Current Employees on Insurance: _____

Employer Contribution: Single: _____Family:_____
If by class, please specify: _____

VEBA☐HSA ☐HRA☐105 ☐ Spending Account Administrator: _____
Employer Contribution: Single: _____ Family: _____
If by class, please specify: _____

Cash or other incentive to employees waiving coverage?: _____

Submitted by (Print Name):_____Date:_____

Telephone: _____Email: _____

******Please attach the most recent renewal exhibit along with all information listed on page 2 and send via secure email. If you do not have access to a secure email, please request one. Unsecure documents will not be accepted.***

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Sales and Underwriting Information Requirements

1. Most recent carrier-documented premium and claims information for the past twenty-four months. De-identified aggregated claims data must be provided in a consecutive monthly format that includes:
   a. Claims and Premiums
   b. Contracts (number of participating employees: listed as single/family and/or other applicable coverage tiers)
   c. Members (individuals covered under the plan)
   d. De-identified high claimant information for any individual claim in excess of $75,000.
   e. Monthly premium rates that coincide with the claims periods
   f. Benefit outlines; summary plan descriptions or summary benefit coverage exhibit that is applicable for the 24 months claims periods. Indicate when the plans applied during the 24 months of claims and premium data provided.

2. Employee census in EXCEL format including the following information:
   a. First and last name of employees, spouses and dependents
   b. Dates of births for employees, spouses and dependents
   c. Gender of employees, spouses and dependents
   d. Home zip codes for employees, spouses and dependents
   e. For groups with more than one plan, indicate plan enrollment for employees, spouses and dependents

3. Provide a separate census list for all continuants (COBRA)

4. Collective bargaining agreement (if applicable)

5. For community-rated groups only: please provide a copy of the most recent list bill/renewal that shows the individual, age rates for all covered employees and their dependents.

Use this section to tell us what you would like to see quoted and any additional things we should know:

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