



**PLEASE COMPLETE THIS REQUEST ELECTRONICALLY
AND EMAIL IT TO YOUR SMALL GROUP SALES EXECUTIVE.**

REQUESTED EFFECTIVE DATE	ERISA GROUP? <input type="checkbox"/> YES <input type="checkbox"/> NO
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EMPLOYER LEGAL NAME				EMPLOYER ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER COUNTY		SIC CODE (4-DIGITS)	NATURE OF BUSINESS	
PRIMARY PRODUCER NAME		EMAIL		PRIMARY PRODUCER NUMBER		REQUESTED PCPM MEDICAL COMMISSIONS (SELECT \$5 INCREMENTS BETWEEN \$20 AND \$80) \$	
GENERAL AGENT NAME (IF APPLICABLE)			EMAIL			GA PRODUCER NUMBER	
NAME OF CURRENT CARRIER					ORIGINAL EFFECTIVE DATE WITH CURRENT CARRIER		
AVERAGE NUMBER OF EMPLOYEES ON PAYROLL DURING BUSINESS DAYS IN THE PRECEDING CALENDAR YEAR (INCLUDE FULL-TIME, PART-TIME AND SEASONAL EMPLOYEES)			TOTAL NUMBER OF ELIGIBLE EMPLOYEES (NOT INCLUDING THOSE ON COBRA OR IN THEIR WAITING PERIODS)		TOTAL NUMBER OF COBRA ENROLLEES (CENSUS SHOULD REFLECT ALL COBRA ENROLLEES)		
TOTAL NUMBER OF ELIGIBLE EMPLOYEES CURRENTLY IN THEIR WAITING PERIODS				TOTAL NUMBER OF PART TIME EMPLOYEES			
TOTAL NUMBER OF ELIGIBLE EMPLOYEES WAIVING WITH NO OTHER COVERAGE				TOTAL NUMBER OF ELIGIBLE EMPLOYEES WAIVING BECAUSE OF OTHER COVERAGE			
EMPLOYER CONTRIBUTION PERCENTAGE (MINIMUM 50% REQUIRED)				HAS THE GROUP BEEN INVOLVED IN BANKRUPTCY PROCEEDINGS EITHER CURRENTLY OR WITHIN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			

MEDICAL QUESTIONS (FOR STOP LOSS QUOTES)

1. HAVE THERE BEEN ANY CLAIMS OVER \$25,000 IN THE PAST 12 MONTHS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
2. IF YES, IS ADDITIONAL TREATMENT EXPECTED WITHIN THE NEXT 12 MONTHS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
3. ARE ANY PARTICIPANTS ON DISABILITY OR NOT ACTIVELY AT WORK?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
4. ARE ANY PARTICIPANTS DIAGNOSED WITH HIGH-RISK CONDITIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN

If you answered **YES** to any of these questions, please attach the patient's birth date, diagnosis, prognosis, onset date, treatment plan and medication. Please **DO NOT** disclose member identifiers like names or ID numbers.

PLEASE SUBMIT YOUR RFP AND THESE REQUIRED DOCUMENTS TO YOUR SALES EXECUTIVE.

Note: all questions must be answered, and all required documentation included to initiate a quote.

<input type="checkbox"/>	CURRENT CENSUS INFORMATION	(Only include members who will participate in the Blue Balance Funded program. Please submit the census on the specially formatted Excel spreadsheet your sales executive provides. Do not modify the census spreadsheet in any way. Modifications will result in load errors and delay your quote.)
<input type="checkbox"/>	CURRENT BENEFIT SUMMARY	
<input type="checkbox"/>	RENEWAL DOCUMENT – MUST INCLUDE CURRENT AND RENEWAL RATES	
<input type="checkbox"/>	LARGE CLAIM INFORMATION (IF AVAILABLE)	
<input type="checkbox"/>	CURRENT CARRIER'S CLAIMS VS. PREMIUMS AND MEDICAL CONDITIONS REPORTS (IF AVAILABLE)	