Request for Proposal – Large Group, 101+ FTE

RFP COVER PAGE

Broker Name: _____

Group Name: _____

Request Date: _____

RBG Office: Select RBG Office RBG Representative: _____

Please indicate below the carriers and lines of coverage you are requesting RBG to quote and complete the attached RFP form. Your RBG team will contact you to discuss quoting strategy.

MEDICAL (indicate medical carriers to quote below)

RBG Large Group Medical Carrier Partners:

☐Blue Shield ☐Cigna Fully Insured ☐Cigna Level Funding ☐Cigna Graded Funding ☐Health Net ☐MediExcel

☐Sharp Health Plan ☐UnitedHealthcare ☐UHC ACEC Trust (for ACEC members or groups eligible for ACEC membership)

Additional Carriers – Indicate below and contact your RBG Representative to discuss availability of a co-broker relationship if you want the group to be quoted, written through and supported by RBG for the following carriers:

☐Aetna ☐Anthem ☐Kaiser ☐Sutter Health Plus ☐Western Health Advantage

Does the group offer coverage to retirees? ☐Yes **OR** ☐No Is the group a non-union carve out? ☐Yes **OR** ☐No

Is this company in or leaving a PEO arrangement? ☐Yes **OR** ☐No If yes, include details in notes below

Is this company on a current Trust plan? ☐Yes **OR** ☐No If yes, include details in notes below

Any known medical claims more than $50,000 in the last 12 months? If yes, include details in notes below	☐Yes **OR** ☐No
Any known pregnancies?	☐Yes **OR** ☐No
If yes, how many pregnancies?	

ANCILLARY (in addition to applicable medical carriers, indicate ancillary carriers and lines to quote below)

RBG Large Group Ancillary Carrier Partners:

☐Choice Builder ☐Guardian ☐Humana ☐MetLife ☐Principal ☐Unum ☐VSP

Ancillary lines to quote:

☐Dental ☐Vision ☐Basic Life/AD&D ☐Voluntary Life/AD&D ☐LTD ☐STD

☐Other: _____

EMPLOYEE ELIGIBILITY – indicate the total number for each category			
FTEs		Number of eligible employees	
Full Time Employees		Employees in waiting period	
Part Time Employees		Active Employees enrolled in medical	
Variable Hour Employees		Active Employees waiving medical	
Union Employees		Enrolled in Kaiser group plan	
Eligible Retirees		Employees not actively at work	

Notes for RBG:

Please return the completed form and required attachments to your RBG Representative

ROGERS BENEFIT GROUP

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BROKER/AGENCY INFORMATION

Agency Name: _____ Producer Name: _____

Street Address: _____

Broker Contact for Account: _____ Phone: _____ E-mail: _____

Broker of Record? ☐Yes **OR** ☐No Broker Commission Requested: _____%

GROUP INFORMATION

Group Name: _____

Headquarter Address: _____

SIC and/or Nature of Business: _____ # of Years in Business:_____

Waiting Period: _____ Total # of Eligible Employees: _____ Total # of COBRA Employees: _____

Employer Contribution: EMP: _____% DEP: _____% Is contribution based on a base plan? ☐Yes **OR** ☐No

(Please note, must be a percentage. Minimum requirement 75% Employee Only or 50% Employee and 50% Dependent)

QUOTE REQUEST DETAILS

Effective Date Requested: _____ Proposal Deadline: _____

Additional Notes:

_____

MEDICAL

Plan Types to Quote: ☐HMO ☐PPO ☐HSA ☐HRA Rate Tiers to Quote: ☐3-Tier ☐4-Tier

Does the employer provide any reimbursement for medical copays? ☐Yes **OR** ☐No If yes, explain in the notes.

☐Check if new line of coverage (virgin group)

Current Medical Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**EF OR EE & 2+**

Renewal Medical Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**ES OR EE ʂ нЬ**

5 Year Medical Carrier History		Period Insured			
Current Carrier:		Start Date:		End Date:	
Prior Carrier 1:		Start Date:		End Date:	
Prior Carrier 2:		Start Date:		End Date:	
Prior Carrier 3:		Start Date:		End Date:	
Prior Carrier 4:		Start Date:		End Date:	

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ANCILLARY

☐**DENTAL** ☐Employer Sponsored ☐Voluntary ☐Check if this is a new line of coverage

Plan Types to Quote: ☐HMO ☐PPO ☐POS

☐Match Current Plan **OR** ☐Benefit to quote: _____

Current Dental Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**EF OR EE & 2+**

Renewal Dental Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**EF OR EE & 2+**

☐**VISION** ☐Employer Sponsored ☐Voluntary ☐Check if this is a new line of coverage

☐Match Current Plan **OR** ☐Benefit to quote: _____

Current Vision Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**EF OR EE & 2+**

Renewal Vision Rates					
Carrier	**Plan**	**EE Only**	**ES OR EE + 1**	**EC**	**EF OR EE & 2+**

☐**BASIC LIFE/AD&D** ☐Flat dollar ☐Times Salary ☐Include Dependent Coverage ☐Check if this is a new line of coverage

☐Match Current Plan **OR** ☐Benefit to quote: _____

Current Rate per $1,000 for Life: _____ AD&D: _____ Renewal Rate per $1,000 for Life: _____ AD&D:_____

☐**VOLUNTARY LIFE/AD&D** ☐Integrated Life & AD&D ☐ Life only ☐AD&D only ☐Check if this is a new line of coverage

☐Match Current Plan **OR** ☐Benefit to quote: _____

Attach Voluntary Life and AD&D Current and Renewal Rates per $1000

☐**LTD** ☐Employer Sponsored ☐Voluntary ☐Base/Buy Up ☐Check if this is a new line of coverage

☐Match Current Plan **OR** ☐Benefit to quote: _____

Current Rate per $100 CME: _____ Renewal Rate per $100 CME:_____ Attach Buy up or age banded Vol LTD rates

☐ **STD** ☐Employer Sponsored ☐Voluntary ☐Base/Buy Up ☐Check if this is a new line of coverage

☐Match Current Plan **OR** ☐Benefit to quote: _____

Current Rate per $10 Benefit: _____ Renewal Rate per $10 Benefit:_____ Attach Buy up or age banded Vol STD rates

CHECKLIST OF REQUIRED DOCUMENTS TO BE INCLUDED WITH REQUEST

☐Group Census in Excel – please download RBG census template and helpful hints for required information.

Note – Most Large Group carriers are now requiring a member-level census to include enrolled dependent first name, last name, DOB, gender and zip code.

☐Current carrier renewals (if available) and most recent invoice for all lines of coverage

☐Benefit Summaries for all current plans for all lines of coverage

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