Blue Cross Blue Shield of South Carolina
An independent licensee of the Blue Cross and Blue Shield Association.

Associations Request for Proposal

Association Requesting Proposal **SCTA**

Producer Requesting Proposal **Scott Woodberry**

Producer Contact #'s **799-4306** **254-7148**
Phone FAX

Prospect Information:

Prospect Name _____

Type of Business _____

Contact & Title _____
Name Title

Address _____
Street or PO Box City State Zip

Contact #'s _____
Phone FAX

Employer Premium Contribution _____ _____
Toward Single Cost Toward Dependent (if Different)

Waiting Period for New Hires _____

Carrier Information:

Carrier Name _____

Renewal Date _____

Rates	**Current**	**Renewal**
Single	_____	_____
Employee & Child	_____	_____
Employee & Spouse	_____	_____
Family	_____	_____

REQUIRED

Please provide a copy of the schedule of benefits from the current carrier's benefit booklet. These are the 1 to 4 pages that show the deductible, copays, coinsurance, out-of-pocket limit, etc.

Total # of employees (full & part time)	_____
Total # of full-time (30 hours/wk, 48 wks/yr)	_____
Total # of part time employees	_____
Total # of full-time employees covered by Medicare	_____
Total # of employees in waiting period	_____
Total # of employees refusing coverage	_____
Total # of full-time employees not actively at work	_____
Total # of employees currently enrolled in health plan	_____

Please attach an employee listing showing: Date of birth, Sex, Currently enrolled type of coverage (i.e. – single, employee & child, employee & spouse or family)

For employers over 100 employees, please provide claims experience.

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EMPLOYER SUPPLEMENTAL INFORMATION

IT IS NECESSARY FOR BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA TO OBTAIN CERTAIN INFORMATION IN ORDER TO ISSUE A PROPOSAL FOR GROUP COVERAGE.

Please complete the following to the best of your knowledge:

1. Did any employee or dependent suffer a condition, which resulted in a claim of $10,000 or more during the last 12 months? ☐ Yes ☐ No

2. Are there any employees or dependents who have been or expect to be treated for a serious medical condition? ☐ Yes ☐ No

3. Is any dependent child over age 19 incapable of self-support because of a physical or mental disability? ☐ Yes ☐ No

4. How many employees and/or dependents are being covered under COBRA continuation? _____ To your knowledge, are there any serious medical problems on this group of continued insured? ☐ Yes ☐ No

   Is anyone covered under COBRA totally disabled? ☐ Yes ☐ No

5. For what period is coverage provided under the extended benefits provision of the current plan? _____Months

6. Is anyone presently covered under the extended benefits provision of the current plan? ☐ Yes ☐ No

7. Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full-time? ☐ Yes ☐ No

8. Are any employees or dependents presently disabled?* ☐ Yes ☐ No

* For an employee, that he or she is absent from work due to injury or sickness
* For a dependent, that he or she is unable to perform the usual and customary activities of a person of like age and sex in good health.

If any of the above questions are answered "Yes", please explain below. Please reference the appropriate question number and give details. If additional space is needed, please use the reverse of this form, or attach a separate page to this form.

_____

_____

_____

_____

Employer: _____

Signature of Applicant: _____

Date: _____ Title: _____

Signature of Agent of Record: _____

If at time of enrollment additional information is available relating to the questions listed above, we reserve the right to change the premium rates quoted or completely withdraw the quotation.