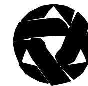
Small Group Proposal Request for 2-50 Lives
Part 1



ASSURANT Health

Attention: Small Group
Regional Sales Office
Fax to 843-881-6225

Phone: 800-726-8825

IMPORTANT

Requesting a Time Insurance small group plan quote <u>requires 3 parts</u>.

1. Completion of ***Part 1*** (Group and Plan Data).
2. Completion of ***Part 2*** (Employee Data) or submission of a similar form with the necessary employee information.
3. Completion of ***Part 3*** (Medical Data). **Medical questions must be discussed with the employer.**

All information must be provided and **all 3 parts must be submitted** in order to receive a new business quote.

Incomplete forms will be returned. Make copies of this form for subsequent requests.

Home Office Use Only:	Factor	UW'R

Agent Information

Agent: ______________________ Agent Number: ______________

Agency Name: ______________________ Email Address: ______________

Fax Number: ______________________ Telephone Number: ______________

Group Information

Name: ____

City: ______________ State: ______________ 5-Digit ZIP Code: ______________

Number of Employees: Full-time: __________ Part-time: __________ On COBRA: __________

Effective Date: ☐ 1st ☐ 15th JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Type of Business: ______________________ SIC Code: ______________

Does employer currently have group medical coverage? Yes No Current renewal premium $ __________

If yes, list group medical carrier: ______________________

Does employer currently have Workers' Compensation? Yes No

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Proposal Request
Part 1 cont'd.

Medical Plan Specifications *(Circle your choices and complete blanks where appropriate.)*

PPO network selection: ______________________________

Lifetime Maximum Benefit: $2 million $5 million $8 million

Plan: HSA HRA Clear Choice Healthy Edge

Annual Deductible: $0 $250 $500 $1,000 $1,200* $1,600 $2,000*

**available with HSA or HRA* $2,400 $2,500* $3,000* $3,500* $4,000* $5,000* $10,000†

†available with HRA For an HRA or HSA, indicate Family Deductible Accumulation: Individual Common Family

Rate of Payment:	50%	60%	70%	80%	90%	100%
Annual Out-of-Pocket Limit:	$1,250	$2,000	$1,500	$1,000	$ 500	
	$2,500	$4,000	$3,000	$2,000	$1,000	
	$5,000		$4,500	$3,000	$1,500	
			$6,000	$4,000	$2,000	

HSA Funding Responsibility *(HSA plans only)*: EE funded ER funded EE/ER funded

Administrator HSATOOLS MSAver Other

Wellness Option YES NO

HRA Plan Design *(HRA plans only)*: EE pays first ER pays first Split deductible Sandwich deductible

HSA or HRA Funding per covered employee:

Single ______% $ ______________ Family______% $ ______________

Office Visit Copay: $20/$20 $20/$30 $20/$40 $25/$25 $25/$40 $30/$30 $30/$50

Hospital Copay *(Healthy Edge only)*: $500 $1,000 $2,000

Maternity (optional 2-14 lives): YES NO

Optional $500 X-ray & Lab Benefit: YES NO

Optional Rx Drug Program: YES NO *(If Yes, complete Rx Deductible and Rx Copay.)*

Rx Deductible: $0 $100 $250 $500 Rx Copay: $15/$45/$60 $15/$35 + 20%/$50 + 20%

Optional Accident Medical Expense: YES NO

(If Yes, select amount.) $300 $500 $1,000 $2,000 $5,000*

** only available with $5,000 or $10,000 deductibles*

Non-Medical Coverages *(Circle your choices and complete blanks where appropriate.)*

Term Life: Level 1 Level 2 Level 3

Minimum $15,000, Maximum $250,000 ($1,000 increments) Maximum additional amounts up to 2 1/2 times prior amount

Disability (Optional): YES *(provide employee salaries)* NO

Duration: 26 weeks 52 weeks Level: 1 2 3 *Minimum $100, Maximum $1,000 ($10 increments)*

See brochure for plan details. ***Circle Plan and Benefit Year Maximum where indicated***

Dental *(Optional)*:	**PPO Plan 1**	**PPO Plan 2**	**Access Plan 1 (or Indemnity)**	**Access Plan 2 (or Indemnity)**	**Access Plan 3 (or Indemnity)**
Benefit Year Maximum:	$1,000/ $750	$1,000/ $750	$1,000 or		
	$2,000/$1,000	$2,000/$1,000	$2,000		
	$2,000/$1,500	$2,000/$1,500			

Orthodontic Coverage *(Groups of 10 or more)*: None Full Family Child Only

Previous Dental YES NO

Waive Waiting Period for Major Services *(Groups of 15 or more)* YES NO

Dependent Participation for Dental ______________ %

EE = Employer ER = Employee

Proposal Request
Part 2

Group Name: ____

Instructions For each employee, circle the appropriate response for **Gender, Medical Coverage, Dental Coverage** (if applicable), and **Life or DI Benefit Level** (if more than one level has been requested). Also, provide **Date of Birth or Age**, **Child Count** for medical (if applicable) and indicate if any employee is on **COBRA**. *See example below.*

For Groups with more than 25 employees, make copies of this page.

Key for Coverage Codes
E = Employee Only S = Employee + Spouse C = Employee + Child(ren) F = Full Family N = No Coverage

EXAMPLE

	DOB	GENDER		MEDICAL COVERAGE					CHILD COUNT	DENTAL COVERAGE					LIFE or DI LEVEL			ON COBRA?
1	5/24/56	M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	N
2	8/16/72	M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	Y
3	MM/DD/YY	M	F	E	S	C	F	N	3	E	S	C	F	N	1	2	3	N

	DOB	GENDER		MEDICAL COVERAGE					CHILD COUNT	DENTAL COVERAGE					LIFE or DI LEVEL			ON COBRA?
1		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
2		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
3		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
4		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
5		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
6		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
7		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
8		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
9		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
10		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
11		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
12		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
13		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
14		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
15		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
16		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
17		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
18		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
19		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
20		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
21		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
22		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
23		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
24		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
25		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	

Time Insurance

Proposal Request
Part 3

Group Name: ______________________________ Date: __________

Number of Medical Certs: Employee Only Employee + Spouse
Employee + Child(ren) Full Family

The employer must provide you with answers to the following questions. How many proposed applicants have/are:

Number of Instances

_________ Incurred medical claims of more than $5,000 during the past 12 months? If yes, give reasons:

_________ Within the past 6 months been disabled or hospital confined? If yes, give reasons:

_________ Currently pregnant? If yes, give due date: ______________________

_________ Been diagnosed as having or received treatment in the past five years for:

a. Cancer or malignancy
b. Heart disorder, heart disease or stroke
c. Acquired immune deficiency syndrome (AIDS) or AIDS Related Complex (ARC)
d. Received treatment for alcohol abuse, drug abuse or chemical dependency
e. Diabetes (insulin-dependent)
f. Any other medical condition that you believe may materially affect premium rates

Provide details for any condition indicated on this page (use additional pages, if necessary):

Proposed rates are not binding and final approval will only be given following receipt and approval of a properly completed application. Any changes in group composition or medical history may require additional evaluation. Assurant Health complies with all state and federal mandated requirements regarding the acceptance and issuance of Small Group medical coverage.

Rates are based on medical history disclosed on this form. If circumstances change, a new quote must be requested.

I discussed these questions with the employer, and to the best of my knowledge, this information is complete and true.

AGENT SIGNATURE______________________________ **DATE** ______________

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Proposal Request for Employee Choice and Remote Employees *Part 4*

For use only with groups that:

1. offer the Employee Choice program or
2. have "remote" employees who either live outside the state or primary PPO area or
3. have employees who work at a second location which is outside the state or PPO area.

Section 1

Complete this section if the employer has selected the Employee Choice program. For each additional plan, indicate the deductible, rate of payment, out-of-pocket limit and network. Then list the line numbers from the Employee Data section of the Proposal Request form for each employee to be enrolled in this plan.

	Plan 2	Plan 3	Plan 4
Deductible:	______	______	______
Rate of Payment:	______	______	______
Out-of-Pocket Limit:	______	______	______
Network:	______	______	______
Employee Line Numbers: *(from Page 3)*	______	______	______

Section 2

Complete this section if the employer has "remote" employees who live outside the state or the primary PPO area. Identify each "remote" employee by the appropriate line number from the Employee Data section of the Proposal Request form. Provide the ZIP code and, if appropriate, the different network choice for each out-of-state employee

Employee Line Number	ZIP Code	Network	Employee Line Number	ZIP Code	Network
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______

Section 3

Complete this section if there is a second work location outside the state or the primary PPO area. Complete the information for the secondary location and list the appropriate line numbers from the Employee Data section of the Proposal Request form for each employee working at the second location.

City	State	ZIP Code
______	______	______

Employee Line Numbers: ____________________

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