BlueCross BlueShield of Texas

Mid-Market Request for Proposal

Please complete your RFP electronically and submit it to:
Mid-Market 51-150: **TexasRFP51100@bcbstx.com**

Group Name:______________________________

Physical Address:______________________________

City, State & Zip:______________________________

Agent Name: ______________________________

Producer Number: ______________________________

Agent Email: ______________________________

Are you the current agent: ☐ Yes ☐ No

SIC: ______________________________

Requested Effective Date:______________________________

Name of current and prior carriers, if applicable (include 3 years of history)______________________________

____

Original effective date(s) with current and prior carriers, if applicable (include 3 years of history) ______________________________

____

Employer Contribution (list either % or $ for employee and/or dependent coverage): ______________________________

Total number of employees on payroll: Full-time: ____ Part-time: ____

Number of full-time employees in waiting period: _____ Length of waiting period. Choices include 0, 30 or 60 days: _____

Number of waivers due to other coverage:______________________________

Total employees enrolling on COBRA (Note: should be included and noted on Census if enrolling):

	YES	**NO**
In the past 12 months, have any claims over $10,000 been submitted?	☐	☐
Are any treatments that may cost or exceed $10,000 expected within the next 12 months?	☐	☐
Are any participants disabled or not actively at work?	☐	☐
Has any participant been diagnosed with a high risk condition?	☐	☐

Examples: Cancer, heart-related problems, AIDS, drug abuse, mental & nervous conditions

Please attach the following with this form:

1. Current Rates

2. Renewal Rates

3. Current Benefit Summary

4. If the answer to any of the medical questions is yes, please attach details about the patient's date of birth, diagnosis, prognosis, onset date, treatment plan and medications.

5. Current Carrier's premium vs. claims and high claims reports. The reports are preferred for groups with less than 50 eligible employees and are required for groups with more than 50 eligible employees.

6. Full census in Excel format – please include:

- All full time eligible employees
- Employee DOB, Gender, State, ZIP code
- Employees who are waiving coverage and the waiver reason
  - WOC = waiving/other coverage
  - WOR = waiving/other reason
- Coverage level (EO, ES, EC or EF)
- Dependent names, DOBs and relationship to employee (spouse or child)

7. PCPM commission rate, if other than the standard $30 Per Contract Per Month (PCPM). ______________________________

*Definition of Valid Waivers - Beginning with Jan. 1, 2014 effective dates, the following will be considered valid waivers due to other enrolled creditable coverage: Other creditable Individual coverage; Other creditable Spousal Group coverage; other creditable Dependent/Child coverage; other creditable Government Insurance Coverage such as Medicaid, Medicare, Tribal, High Risk Pool, Tricare/Military, Individual Exchange, SHOP.

Appointed agents should hold requests until all information has been obtained from the prospective client. Once all information has been gathered and this form is complete, please send this form and attachments to TexasRFP51100@bcbstx.com. Underwriting will review and will provide rates based on this information. Please be aware, rates could be impacted if information outlined on this form is not provided. Thank you for allowing us to provide a rate proposal for this prospective client.

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