MONTANA REQUEST FOR QUOTE: LARGE GROUP (51+)

PacificSource HEALTH PLANS

Email the request for quote to:
MontanaSales@pacificsource.com
or fax: (406) 422-1010

Date: _____

Please allow 7–10 working days for quote to be finalized.

Deadline for quote: _____

AGENT INFORMATION

Agent: _____ Email: _____ Phone: _____

Commissions (specify as percentage of premium, PEPM, PMPM, or a fixed dollar amount): _____

GROUP INFORMATION

Legal name of group: _____

Street address: _____

City: _____ State: ____ Zip code: _____ County: _____

SIC Code: _____ Or nature of business (description of work involved): _____

PLAN INFORMATION

Coverage requested: ☐ Medical ☐ Pharmacy (Rx) ☐ Dental ☐ Vision

_____ Requested effective date (mm/dd/yyyy)

☐ Yes ☐ No Does the group have current medical coverage?

Name of carrier(s) for the past 3 years: _____

☐ Yes ☐ No Does the group have current dental coverage? Name of Current Carrier: _____

☐ Yes ☐ No Would the group like to match current deductible, co-pay, co-insurance, and out-of-pocket limit?

☐ Yes ☐ No Would the group like deductible credit?

☐ Self ☐ PSA Will COBRA be self-administered (self) or PacificSource Administrators (PSA)?

☐ PY ☐ CY Is the current benefit period a plan year (PY) or calendar year (CY)?

_____ Employer contribution to *employee* premium (minimum of 75% of employee rate including medical, Rx, dental, and vision)

_____ Employer contribution to *dependent* premium

_____ Minimum Hours — how many hours per week must an employee work to be eligible?

_____ Probationary period requirement

CENSUS INFORMATION (75% participation is required)

_____ Total number of current employees

_____ Number of *eligible* employees (works the group's required hours and has met the probationary period)

_____ Number of employees waiving for other group coverage

_____ Number of employees waiving for individual coverage or no other coverage

_____ Number of employees in probationary period

_____ Number of current COBRA participants

_____ Number of current retiree participants

QUOTE REQUEST CHECKLIST (please provide the following documents)

☐ **Census** (in electronic Excel document format), including:

1. Member name
2. Date of birth
3. Contract type
4. Zip code
5. Benefit plan
6. Class (active/retiree/COBRA)
7. Eligible: Y=eligible as active employee
   PT = not eligible due to hours
   PP= not eligible due to probationary period
8. Waivers including waiver type (group, individual, none)

Note: Our **Large Group Census** form is available at PacificSource.com under Agents > Forms and Materials > Montana.

☐ **Existing Benefit Description** (full summary plan description, outline of coverage, or member benefit handbook).

☐ **Current Rates** by contract type (EO, ES, EC, EF), including the benefit and coverage (medical, Rx, dental, and vision).

☐ **Renewal Rates** by contract type (EO, ES, EC, EF), including the benefit and coverage (medical, Rx, dental, and vision).

☐ **Last billing statement —** include a copy showing employees' names (for existing or prior insurance) if available.

☐ 24 months of claims experience, including number of contracts, members, premiums, and claims by month and benefit plan.

☐ 24 months of large claimants over $10K with diagnosis/prognosis. Two reports: most current 12 months and previous 12 months.

Note: If the group cannot provide claims experience, please provide health statements for all enrolling.