



RATE QUOTATION FORM

Please complete and e-mail to

NewtoBlue@highmark.com

or fax to 412-544-2292

v. 04.01.2007

DATA SUBMITTED

Please submit the following with the quote:

- A complete census containing the information listed at the top of page two ;
- Twelve to 24 months of month by month claims experience (broken down by group) with separate medical and drug information ;
- For all claims greater than \$50,000, the claim amounts as well as diagnosis and prognosis information ;
- A detailed benefit grid for all current plan options ;
- The previous, current, and renewal rates for all current plans ;
- Client's most current UC-2 form (if available)

GROUP INFORMATION

Requested Effective Date _____ Current Carrier Renewal Date _____

Group Name _____

Group Contact Person/Title _____ Contact Phone Number _____

Street Address _____

Zip Code _____ City _____ State _____ County _____

EIN - Employer ID #s _____ How long has the client been in business? _____

Client part of an Association or Trust Fund? YES NO Does the client include Union employees? YES NO

If Yes, Name _____ If yes, Union Name / Local Number _____

If the requested effective date and current renewal date are not the same, please explain.

PRODUCER INFORMATION

Agency Number _____ Commission % _____

Producer / Agency Name _____

Agency Phone Number _____ E-mail Address _____

Agency Fax Number _____ Are you the incumbent Producer? YES NO

INDUSTRY INFORMATION

SIC Code _____ Industry Description _____

CLIENT SIZE / PARTICIPATION

Total Employees		Provide reason for ineligibility (ex. PT, waiting period) here
Number of Employees not eligible for coverage		
Number of Spousal Opt-Outs		
Number of Other Waivers		
Number of Employees on Short Term Disability		
Number of Active Employees		
Number of COBRA Contracts		

What was the number of employees 1 year ago? _____

What is the average annual turnover percentage the past 3 years? _____

EMPLOYER CONTRIBUTIONS

CHOOSE A CONTRIBUTION METHOD Monthly dollar amount Percentage

Individual _____ Family _____ Other _____

Is there an incentive for opting out? YES NO

If Yes, please define _____

Is the group planning changes to contributions? YES NO

If yes, please explain _____



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CENSUS INFORMATION

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Please attach a complete census of all employees with the following minimum information.

- Gender
- Date of Birth
- Home zip codes
- Employment status (FT, PT, COBRA, disability, spousal opt out, other waiver)
- Contract Type (Individual, Parent & Child(ren), Husband & Wife, Family)
- Enrolled plan identification (if employees are currently offered more than one plan)

RATING INFORMATION

Current Rating Method _____ Requested Rating Method _____

If the Client is requesting to change rating methods, please provide an explanation.

SHOCK CLAIM INFORMATION

Are you or the group aware of any current claims greater than \$50,000? YES NO UNKNOWN

If Yes, please provide the claim totals for each and attach all diagnosis/prognosis information available

Amount	Diagnosis / Prognosis

CURRENT / PRIOR CARRIER INFORMATION

Has any portion of the client ever been insured with Highmark? YES NO

CARRIER HISTORY

Please list for the previous 5 years (most recent first)

CARRIER _____ Effective Dates (From / To) _____

If Yes, Effective Date _____
Cancel Date _____

Current _____

Previous _____

Previous _____

Previous _____

Previous _____

Former Highmark group numbers

Is the current carrier a TPA? YES NO

RATE HISTORY

	Effective Date	Line of Business	Individual	Parent / Child	Parent/Children	Husband/Wife	Family
Renewal Rates							
Current Rates							
Previous Rates							

If you have additional plans, please attach rates and benefit provisions.

ADDITIONAL INFORMATION

Does the group currently offer group health insurance to its employees? YES NO

Are the current carrier rates demographically or experience rated or a combination? _____

What is the new hire waiting period for group health benefits? _____ (i.e. date of hire, 30 days, 60 days, etc)

SUPPLEMENTAL PRODUCTS

List supplemental coverage

Dental _____

Vision _____

Worker's Compensation _____

ADDITIONAL QUOTE INFORMATION OR COMMENTS