

**Section 1: Broker information**

Broker firm: \_\_\_\_\_ Date submitted: \_\_\_\_\_  
 Contact name: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Are you the group's current broker of record?  No  Yes Commission requested (if 100+): \_\_\_\_\_  
 If no, state your relationship to the group: \_\_\_\_\_

**Section 2: Company information**

Company \_\_\_\_\_ Contact name: \_\_\_\_\_  
 Address: \_\_\_\_\_ County: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Current carrier: \_\_\_\_\_ # EEs: \_\_\_\_\_ SIC code: \_\_\_\_\_  
 Current plans: \_\_\_\_\_ # OOA EEs: \_\_\_\_\_ Industry: \_\_\_\_\_  
 Benefit grids included?  No  Yes Renewal date: \_\_\_\_\_  
 Does company have workers' comp?  No  Yes Requested effective date: \_\_\_\_\_  
 Has company been in business at least 3 months?  No  Yes How long has client been with current carrier? \_\_\_\_\_  
 Company has union employees?  No  Yes If "Yes," local name: \_\_\_\_\_  
 Are benefits through an association?  No  Yes Association Name? \_\_\_\_\_  
 Is company a former UPMC Health Plan client?  No  Yes If "Yes," when? \_\_\_\_\_  
 Is there a Section 125 plan now in effect?  No  Yes  
 Reason  Cost  Network  Benefit designs  
 account is out  Customer service  Health care management  
 for bid: \_\_\_\_\_

Notes:

**Section 3: Premium/Claims information\***

	Previous premium	Current premium	Renewal premium	Amount paid by employer	
				Employee	Dependents
Single					
Parent & child					
Parent & children					
Husband & wife					
Family					

\*For groups with more than 100 eligible employees, include monthly data for 12 to 24 months of claims (separate medical from pharmacy) and enrollment experience. Claims greater than \$50,000 must include diagnosis and prognosis by experience period.

**Section 4: Census information**

Please attach a complete census that includes a **name, date of birth, gender, coverage tier, zip code, and current plan option (if multiple plans offered)** for EACH eligible employee. You must include ALL eligible employees, even if they are choosing to waive coverage. Please clearly list all out-of-area employees. Electronic census is preferred. For employees waiving coverage, please indicate whether proof of the other coverage is required.

**Section 5: UPMC Health Plan products**

**Benefit options requested:** (Please indicate specific options, such as PPO 8, HRA 2, etc.)

HMO	PPO	EAPOS	Rx Plan:
EPO	HRA	HSA	OOA