

Proposal Request Form

Health Tradition Health Plan
 Sales & Marketing
 1808 East Main Street, Onalaska, WI 54650
 P.O. Box 188
 La Crosse, WI 54602-0188
 Toll Free 1-888-459-3020
 Fax 1-608-781-4620

Section 1: Account Information

	Date
Company Name	
Contact Person/Telephone	
Nature of Business/SIC	
Street Address	
City, State, Zip	
Other Locations (city, state, zip, and # employees per location)	
Agency Name	
Agent Name	

Section 2: Employee and Eligibility Information

1. Attach employee census showing dates of birth (or age), gender, coverage status (no coverage, single coverage, family coverage, etc.), home zip code, COBRA status, active or retiree, and work location (if company has multiple locations).
2. Total Employees (including part-time): _____
 Total Number of Eligible Employees: _____
 Definition of an Eligible Employee (hours per week): _____
3. Number of current insured employees: a) Active _____ b) COBRA _____
 c) Retirees _____ d) Part-time Employees _____ e) **Total** _____
4. Waiting period for new employees: _____.
5. Are retirees eligible to be covered under your plan? Yes (please provide eligibility rules); No

6. Amount(\$ or %) of employer contributions to the plan (actives and retirees). _____
7. Have you experienced in the past two years, or do you anticipate over the next year, increases or decreases in enrollment in excess of 10%? Yes (please explain) No

8. Are there any employees, retirees, or dependents to be covered that are disabled (including those on COBRA)? Yes -- please provide name and nature of disability No

Section 3: Plan Information

1. Current number of health plans offered: _____
2. Provide a full plan document for each current plan (i.e. summary plan description or coverage certificate). Indicate any changes in benefits desired. If there have been any changes in coverage during the last two years, include a description and dates of changes.
3. Current plan type(s): Indemnity; PPO; Point-of-Service HMO; HMO
4. Current Plan funding: Fully insured; Fully insured (refund); Fully insured (retro);
 Minimum premium; Partially self-insured; Totally self-insured (no stop-loss)
5. Current renewal date: _____ Proposed effective date (new plan): _____
6. Proposed Plan: Total Replacement; Dual Carrier Situation; Multiple Carrier Situation
7. Provide the following plan/rate information:
(a) for self-insured plans--third-party administrator and COBRA-equivalent rate history;
(b) for insured or HMO plans--health plan carrier and 3 year rate history
8. Would you like specific rate-ratios quoted? Yes (please provide ratios) No

Section 4: Claims Information

1. Claims are reported as (check one): Paid Incurred
2. Attach claims and premium experience *for the most recent two years with the most recent data not more than 6 months (3 months preferred) prior to the proposed effective date:*
 - ◆ Month-by-month claims (if incurred claims are not available, provide paid claims)
 - ◆ Month-by-month number of contracts by coverage type (i.e. single, family, etc.)
 - ◆ For fully insured plans, month-by-month premium information
 - ◆ If claims information is not available, refer to Section 3, 7.b above
3. Provide individual large claims in excess of the following amounts for the *most recent two years:*
 - (a) for self-insured plans—\$10,000 or 50% of the Specific (individual) stop loss deductible;
 - (b) for insured or HMO plans—\$10,000.

For (a) or (b) above, please provide the following:

 - ◆ Name & Age
 - ◆ Status of individual (actively at work, medical leave, disabled)
 - ◆ Diagnosis & Prognosis/Expected future claims
 - ◆ Current and proposed course of treatment
 - ◆ Last hospitalization date
 - ◆ Total amount of claims
4. **Are the individual(s) with large claims still covered under the plan?** YES NO

Section 5: Benefit Design Request

Plan Design Option(s) to Quote:	Plan #1	Plan #2	Plan #3
Plan (HMO or POS)	HMO / POS	HMO / POS	HMO / POS
Consumer Choice (HRA)	Yes / No	Yes / No	Yes / No
If yes - \$ Amount	_____	_____	_____
Funding % (50-100)	_____	_____	_____
Community	Yes / No	Yes / No	Yes / No
Deductible			
In-Network	\$_____ member	\$_____ member	\$_____ member
	\$_____ family	\$_____ family	\$_____ family
Out-of-Network	\$_____ member	\$_____ member	\$_____ member
	\$_____ family	\$_____ family	\$_____ family
Coinsurance			
In-Network	_____%	_____%	_____%
Out-of-Network	_____%	_____%	_____%
Office Visit Copay	\$_____	\$_____	\$_____
ER Copay	\$_____	\$_____	\$_____
Hosp. Admission Copay	\$_____	\$_____	\$_____
Out-of-Pocket Maximums			
In-Network	\$_____ member	\$_____ member	\$_____ member
	\$_____ family	\$_____ family	\$_____ family
Out-of-Network	\$_____ member	\$_____ member	\$_____ member
	\$_____ family	\$_____ family	\$_____ family
Prescription drugs (standard \$2500/\$4000)	\$_____ member	\$_____ member	\$_____ member
	\$_____ family	\$_____ family	\$_____ family
Prescription Drug Copays	\$_____ Generic	\$_____ Generic	\$_____ Generic
	\$_____ Brand	\$_____ Brand	\$_____ Brand
	\$_____ Non-Form	\$_____ Non-Form	\$_____ Non-Form
Self-administered injectables (standard 20%)	_____%	_____%	_____%
Diabetic drug copays (standard \$15/\$30)	\$_____ Formulary	\$_____ Formulary	\$_____ Formulary
	\$_____ Non-Form	\$_____ Non-Form	\$_____ Non-Form
Diabetic Supplies Copay (includes 50 test strips, 100 syringes or 200 lancets)	\$10 for each	\$10 for each	\$10 for each

Note: Routine physical exams & well-baby care, Immunizations, Routine eye exams, and Routine hearing exams will be covered at 100% when using In-Network Providers only.

Section 6: Riders

