

Group Benefits - Request For Proposal



Group Name:

Effective Date:

HEALTH

Coverage Type: Level funded (partially self-funded) Fully insured

DENTAL

Voluntary Non-Contributory Contributory %:

Calendar Year Max: \$1,000 \$1,500 Other:

Orthodontia Coverage: Yes No Both

Deductible: \$50 Annual \$100 Lifetime Other:

Coinsurance %: 100/80/50 100/90/60 Other:

Out of Network Reimbursement: % of U&C: Maximum Allowable Charge (MAC):

Endodontics: Basic (Type II) Major (Type III) Periodontics: Basic (Type II) Major (Type III)

Assumptions: Includes annual enrollment period.

VISION

Voluntary Non-Contributory Contributory %:

Co-Pays: \$10/\$10 \$10/\$25 \$20/\$20 Other:

Frame Allowance: \$110 \$130 \$150 Other:

Frames Frequency: 12 months 24 months Other:

LIFE

Voluntary Non-Contributory Contributory %:

Benefit: \$25,000 \$50,000 \$100,000 1x Salary 2x Salary 3x Salary Other:

Dependent Life:

SHORT-TERM DISABILITY

Voluntary Non-Contributory Contributory %:

Weekly Benefit: 60% 66.67% Other:

Weekly Benefit Maximum: \$500 \$750 \$1000 Other:

Elimination Period (Accident/Sickness): 0/7 14/14 Other:

Maximum Benefit Period: 13 weeks 26 weeks Other:

Gross Up Option:

LONG-TERM DISABILITY

Voluntary Non-Contributory Contributory %:

Monthly Benefit: 60% 66.67% Other:

Monthly Benefit Maximum: \$5000 \$10,000 Other:

Elimination Period: 90 days 180 days Other:

Maximum Benefit Period: SSNRA or RBD 5 years or Age 70 Other:

Own Occupation Period: 24 months Other:

Gross Up Option

Group Benefits - Quote Requirements

HEALTH

- First & last name
- Date of birth
- Gender
- Zip code

DENTAL

- Date of birth (*dependents DOB's, if available*)
- Gender
- Elections
- Home zip code
- For groups of 100+ employees we will need 24 months of claims information.

VISION

Any of the following will work:

- Census with date of birth and gender
- Number of participating lives
- Number of employees in each tier

LIFE

- Date of birth
- Gender
- Salary (for benefits with a % of salary)
- Multiple Classes - please provide class for each EE
- Groups of 1000+ please provide 24 months of claims reports (open, closed, paid vs. premium)

Dependent Life - Please provide the date(s) of birth for all dependents.

SHORT-TERM DISABILITY

- Date of birth
- Gender
- Salary
- Multiple Classes - please provide class for each EE
- For groups of 100+ employees we will need 24 months of claims information (open, closed, paid vs. premium)

LONG-TERM DISABILITY

- Date of birth
- Gender
- Salary
- Occupation
- Multiple Classes - please provide class for each EE
- Groups of 250+ we will need 24 months of claims reports (open, closed, paid vs. premium)

CURRENT COVERAGE

- Current Carrier
- Rates (both current & renewal)
- Voluntary Lines - please provide current volumes
- Contracts and/or benefits summary for each line of coverage
- Employer contribution
- Reason for shopping / most important item for the group