South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Associations Request for Proposal

Association Requesting Proposal South Carolina Automobile Dealers Association

Producer Requesting Proposal **John Wofford**

Producer Contact #'s 864-672-1306 (Phone) 888-751-3014 (FAX)

Prospect Information:

Prospect Name _____

Tax ID # _____

Type of Business _____

Decision Maker Contact & Title _____ (Name) _____ (Title)

Billing Contact Name _____ (Name) _____ (Title)

Billling Contact _____ (E-Mail) _____ (Phone Number)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (PO Box) _____ (City) _____ (State) _____ (Zip)

Contact #'s _____ (Phone) _____ (FAX)

Employer Premium Contribution _____ (Toward Single Cost) _____ (Toward Dependent (if Different))

Waiting Period for New Hires _____

Carrier Information:

Carrier(s) Name Last 2 Years _____

Date last insured by the Association _____

Last renewal percent increase _____

Renewal Date _____

Please attach **REQUIRED:**

1) **Employee census showing all full-time eligible employees and covered dependents. Please use Excel census template located on SCADA website. Census should include all full-time Employees even if they do not participate in your current plan. (Complete requested dependent information to the best of your knowledge for any dependents who are currently enrolled in the medical plan - Dep Census is located on the second tab of the Excel Template)**

2) **A Current bill showing all covered employees and the monthly medical premiums**
3) **A Schedule-A rate sheet if your plan has monthly premium rates based on individual age of each employee**
4) **A Schedule of current medical benefits (should include deductible, copays, coinsurance, out-of-pocket limits, etc.)**
5) **A Copy of your 2020 medical renewal (if available)**

NOTES:

6) **Groups 50 and under may have to complete health applications**
7) **Groups 2 - 25 MUST have each Employee complete a Personal Health Statement (form located on SCADA website). Please submit Health Statements along with completed Census data.**

For employers over 100 employees and those under 100 that are currently covered by a level-funded or self-funded plan, please provide claims experience. (2 years claims experience and enrollment by month, plus the shock claims information for the same time period)

Employer Supplemental Information

(Complete to the best of your knowledge)

It is necessary for Blue Cross Blue Shield of South Carolina to obtain certain information in order to issue a proposal for group coverage. Please complete the following to the best of your knowledge.

		YES	NO
1.	Did any employee or dependent suffer a condition which resulted in a claim of $10,000 or more during the last 12 months?	___	___
2.	Are there any employees or dependents who have been or expect to be treated for a serious medical condition?	___	___
3.	Is any dependent child over age 19 incapable of self-support because of a physical or mental disability?	___	___
4.	How many employees and/or dependents are being covered under COBRA continuation? _____		
	To your knowledge, are there any serious medical problems on this group of COBRA continuation insureds?	___	___
	Is anyone presently covered under COBRA totally disabled?	___	___
5.	Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full-time?	___	___
6.	Are any employees or dependents presently disabled? *		
	* For an employee: he or she is absent from work due to injury or illness; * For a dependent: he or she is unable to perform the usual and customary activities of a person of like age and sex in good health.	___	___
7.	Carriers for the last five (5) years and length of time with each carrier:		

_____

_____

If any of the above questions were “YES”, please explain below (write the question number and give details):

_____

_____

_____

Employer:_____ Date:_____

Signature of Applicant: _____ Title:_____

Signature of Agent or Record:_____