

# Request For Proposal 51-199 Eligible Employees



**CaliforniaChoice 51+**  
Your Health. Your Choice.®

721 South Parker, Suite 200, Orange, CA 92868  
(800) 542-4218

**Fax completed form to (866) 388-8334 or (714) 664-1710**

**TO EXPEDITE YOUR REQUEST FOR A QUOTE, PLEASE OBSERVE THE FOLLOWING:**

- ✓ Verify Eligibility:
  - Employer must have a minimum of 51 eligible employees and a maximum of 199 eligible employees (COBRA excluded).
  - Eligible employees are permanent, active, full-time employees working a minimum of 30 hours per week.
  - Ineligible employees include part-time (employees working less than 30 hours per week), seasonal, temporary, per diem, 1099, union, board members, retirees and employees on a leave of absence not categorized as FMLA, Workers' Compensation or Military.
  - 70% of eligible employees must enroll with a minimum of 40. Employees waiving due to other group coverage are not counted toward participation requirements unless the employer contribution is 100%.
- ✓ Fill out the Request For Proposal in its entirety; do not leave any items blank. Provide answers and details as requested and write in "NA" or "0" as needed.
- ✓ Include a copy of the current carrier's most recent Renewal Quote and Billing Statement in lieu of completing Section F—"Medical Carrier Information."
- ✓ Include current employee medical census. For the most accurate quote, follow the sample census below:

Employee Name	Date of Birth (or age)	Gender (M or F)	Currently Enrolled?		Employee Zip	Life Coverage (Y or N)	✓ if COBRA
			✓ if spouse	# of children			

**If rates calculated at enrollment are more than 5% higher than quoted rates, your group is subject to the higher enrollment rates.**

**GA Information**

GA Sales Rep. Name:	GA Office:	Delivery of Proposal: <input type="checkbox"/> Pick-Up <input type="checkbox"/> Mail <input type="checkbox"/> E-Mail to: _____
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**A. Broker Information**

Broker Name	Broker Code	Agency
Address		
Phone ( )	Fax ( )	Delivery of Proposal: <input type="checkbox"/> Pick-Up <input type="checkbox"/> Mail <input type="checkbox"/> E-Mail to: _____
Is This The Current Broker of Record? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**B. Employer Information**

Employer Name	Effective Date	
Address		
Phone ( )	Fax ( )	
Exact Nature of Business	SIC Code	Business Start Date

**C. Rating Tiers**

Select the rating tier option for your group: <input type="checkbox"/> 2 tier: EO, EF <input type="checkbox"/> 3 tier: EO, E+1, E+2 <input type="checkbox"/> 4 tier: EO, ES, EC, EF	Employer Contribution Toward Current Plan:
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**D. Eligibility Information**

1. Total number of employees on payroll: \_\_\_\_\_
2. Total number of eligible employees: \_\_\_\_\_  
(Eligible employees are permanent, active, full-time employees working a minimum of 30 hours per week. The following classifications are NOT eligible: employees working less than 30 hours per week, leased employees, seasonal employees, 1099, union, board members, retirees, COBRA participants or surviving spouses.)
3. Are all eligible employees covered by Workers' Compensation?  Yes  No  
If no, explain: \_\_\_\_\_
4. Total number of part-time employees: \_\_\_\_\_
5. Total number of employees currently enrolled in your group medical coverage? \_\_\_\_\_
6. Total number of employees currently covered by their spouse's medical coverage? \_\_\_\_\_
7. Total number of dependents currently enrolled in your group medical coverage? \_\_\_\_\_
8. Total number of COBRA participants\* currently enrolled in your group medical coverage? \_\_\_\_\_

\*COBRA participants must be listed on the census. Current carrier should be contacted for a more accurate count.

## E. Health Information

Please answer the following questions to the best of your knowledge regarding ALL eligible enrollees (employee, dependents, COBRA, proprietors and partners).

Have any eligible enrollees:

1. Been hospitalized during the past 12 months?  Yes  No
2. Been diagnosed with or being treated for cancer, brain tumor, blood disease, heart disease or heart disorder, stroke, AIDS, AIDS related conditions, nervous system disorder, mental condition, liver/kidney disease, birth defect, transplant, or any other medical condition?  Yes  No
3. Received medical benefits in excess of \$50,000 in the last 12 months for any condition other than those listed above?  Yes  No

Are any eligible enrollees:

4. Currently pregnant? If yes, provide total number of pregnancies: \_\_\_\_\_  Yes  No
5. Currently expecting a multiple birth? If yes, provide total number of enrollees: \_\_\_\_\_  Yes  No
6. Currently disabled? If yes, provide total number of disabled: \_\_\_\_\_  Yes  No

**Please provide details below for any "yes" responses for the above health questions 1-6. If additional space is required, please provide on a separate sheet of paper. Each enrollee listed below may be required to complete an Individual Health Questionnaire (Form # PL 0568).**

EE	Exact Diagnosis	Date of Diagnosis	Date of Last Treatment	Details
1				
2				
3				
4				

## F. Medical Carrier Information

<b>Total Group Premium for Current Medical Coverage:</b>	<b>Total Group Premium for Current Medical Coverage Renewal:</b>	<b>Employer Contribution for Current Medical Coverage:</b>

Provide information for all current medical plans below or provide a copy of the most recent billing statement and renewal from each carrier:

PLAN 1			PLAN 2				
Plan Name	<b>Check rate tier option and provide RENEWAL rates:</b>			Plan Name	<b>Check rate tier option and provide RENEWAL rates:</b>		
Carrier Name & Policy #	<input type="checkbox"/> 2 Tier	<input type="checkbox"/> 3 Tier	<input type="checkbox"/> 4 Tier	Carrier Name & Policy #	<input type="checkbox"/> 2 Tier	<input type="checkbox"/> 3 Tier	<input type="checkbox"/> 4 Tier
Effective Date	EO Rate _____	EO Rate _____	EO Rate _____	Effective Date	EO Rate _____	EO Rate _____	EO Rate _____
Renewal Date	EF Rate _____	EE+1 Rate _____	ES Rate _____	Renewal Date	EF Rate _____	EE+1 Rate _____	ES Rate _____
		EE+2 Rate _____	EC Rate _____			EE+2 Rate _____	EC Rate _____
			EF Rate _____				EF Rate _____
PLAN 3			PLAN 4				
Plan Name	<b>Check rate tier option and provide RENEWAL rates:</b>			Plan Name	<b>Check rate tier option and provide RENEWAL rates:</b>		
Carrier Name & Policy #	<input type="checkbox"/> 2 Tier	<input type="checkbox"/> 3 Tier	<input type="checkbox"/> 4 Tier	Carrier Name & Policy #	<input type="checkbox"/> 2 Tier	<input type="checkbox"/> 3 Tier	<input type="checkbox"/> 4 Tier
Effective Date	EO Rate _____	EO Rate _____	EO Rate _____	Effective Date	EO Rate _____	EO Rate _____	EO Rate _____
Renewal Date	EF Rate _____	EE+1 Rate _____	ES Rate _____	Renewal Date	EF Rate _____	EE+1 Rate _____	ES Rate _____
		EE+2 Rate _____	EC Rate _____			EE+2 Rate _____	EC Rate _____
			EF Rate _____				EF Rate _____

Provide medical carrier history for the last 5 years:

Medical Carrier Name	Coverage Type: (PPO, HMO, POS)	Effective Date	Group Policy #	Termination Date	Reason for Termination

**I certify that the information provided on this Request For Proposal is true and correct to the best of my knowledge:**

\_\_\_\_\_  
Employer Signature Print Name Date

\_\_\_\_\_  
Broker Signature Print Name Date

CaliforniaChoice **51+** will rely on the information provided to determine whether a proposal will be valid. CaliforniaChoice **51+** reserves the right to rescind any proposal, revise rates, or deny the approval of coverage.

**For questions, please contact your large group underwriter at (800) 542-4218, extension 4499**