**Shared Advantage/Shared Advantage Plus/Stop Loss Proposal Request Form**

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| **Instructions: (Please send your quote requests to SAQuotes@blueshieldca.com)**  **What we need to quote Shared Advantage/Shared Advantage Plus:**   * Complete Parts 1, 2, and 4 of this form * Submit a census in Excel format that includes employee zip codes, coverage tiers (minimum of 3), employee status * Submit a copy of the group’s current plan designs |
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**Part 1 – Requester Information**

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| TPA: | TPA Salesperson: | Date Submitted: |
| Due Date to TPA: | | Group Effective Date: |
| Request Zip Code Discount Analysis:  YES  NO | | Request Geo Access:  YES  NO |
| Request Questionnaire Assistance:  YES  NO  If Yes, Please Identify/Attach the Sections/Questions You Need Answered: | | |
| Blue Shield of CA Salesperson Name: | | |
| Shared Advantage Plus Quote or  Shared Advantage Quote **(requires BSC approval)**  Stop Loss Quote    Build Blue Card access fees into PEPM SA Fee  YES  NO  Tiered Network  YES  NO **(requires BSC approval)**  Shield Savings  YES  NO | | |
| Requested Target SA/SA+ Fee $\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Mandatory Field)** | | |
| Does TPA have a current BAA and/or NDA on file with Prospect?  YES  NO   * If no, confirmation will be required prior to implementation of the client with Blue Shield. | | |
| Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Part 2 – Prospect/Broker Information**

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| Prospect Name: | | | |
| Group’s Corporate Headquarters (Complete Address): | | | |
| Broker Firm Name: | | Individual Broker Name: | |
| Broker Firm Complete Address: | | | |
| Broker Contact Number: | Eligible Employees: | | Covered Employees: |
| Quote including Kaiser Employees  Quote excluding Kaiser Employees  Quote w/ & w/o Kaiser    Other Exclusions (Specify):­­ | | | |
| Quote Out of State Employees  Include Retirees in quote | | | |
| Is this a tribal account requiring Medicare Like Pricing (MLR):  YES  NO | | | |
| Is group currently self-funded?  YES  NO  If yes, please include current contract, if available. | | | |
| Why is group out to bid?  Bid check  Unhappy with current carrier  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_    What is needed to win group?  Competitive overall fee. If so, what is target network fee? \_\_\_\_\_\_\_\_  Network access/disruption  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Current Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Admin Fee: \_\_\_\_\_\_\_\_\_\_\_\_ Current Network Access Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is Group Interested in Purchasing Value Added Services?  YES  NO  Current Value-Added Services (list and provide cost, if known): | | | |
| Additional Requests: | | | |

**Part 3 – What we need to quote Stop Loss (complete for all stop loss requests)**

* Census in Excel format that includes DOB, gender, employee zip codes, coverage tiers (minimum of 3), employee status, plan type, COBRA participants identified, retirees identified if covered

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| Does group currently have Stop loss Coverage?  YES  NO  If yes, please provide Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Please include current stop loss contract (if available).   Claims Experience (please include):   * 24 months of monthly medical and Rx claims experience, including subscriber counts * 3 years of large claims information for both Medical & Rx including diagnosis and dollar amounts * If Rx is carved out from current carrier;   Individual large claimant report based on 25% of lowest requested SSL deductible.  Monthly paid Rx claims for 24 months if aggregate coverage requested. | | | | |
| **Current Stop loss Information:** | | | | |
| Current Specific Rate: | Current Specific Deductible: | Current Specific Contract Type: | Current Commission: | Current Annual Maximum (if applicable): |
| Current Aggregate Rate: | Current Aggregate Factor: | Current Aggregate Contract Type: | Current Aggregate Corridor: | Current Aggregate Reimbursement: |
| Contingencies or Any Lasers/ Aggregating Specific (provide details): | | | | |
| **Requested Stop loss Information:** | | | | |

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| Requested Stop Loss Commission %: | | Net of Commission:  YES  NO |
| Deductible:  $100,000 $125,000 $150,000 $200,000 $225,000 Other (specific)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Lifetime Maximum Requested:  Unlimited Annual Max Other (Specify) \_\_\_\_\_\_\_\_\_ | | |
| Contract Type:  12/12 12/15 12/18 15/12 24/12 Other (specify) | | |
| Attachment Point:  120% 125%  Other (specific) | | |
| Benefits Covered - Specific:  Medical Only Medical and Rx Other (specify) | Benefits Covered - Aggregate:  Medical Only Medical and Rx Other (specify) | |

**Part 4 – Additional Information/Notes/Requests for Shared Advantage and/or Stop Loss:**

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| Additional Information/Notes/Requests: |
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