



New Business Quote

SECTION I GENERAL INFORMATION

Group Name: _____
 Contact Name: _____
 Billing Address: _____
 City: _____ State: _____ ZIP: _____
 Phone Number: _____
 Fax Number: _____
 Contact Email: _____

MUST Representative: _____
 Agent Name: _____
 Agent Employer: _____
 Agent Phone Number: _____
 Agent Address: _____
 City: _____ State: _____ ZIP: _____
 Agent Email: _____

SECTION II GROUP DATA

Requested Effective Date: _____
 Months in Benefit Year: _____
 Total # of Employees: _____
 If a husband and wife are both employees, are they usually set up under two policies or are they set up as employee/spouse? _____
 How is your employer contribution handled for this situation?

Eligible classes of employees:
 Certified Classified Other: _____
 With the current carrier can a dependent of a Medicare eligible retiree who drops their coverage continue on their own plan?

SECTION III MUST QUOTE

Plans Quoting: _____
 Tiers: Standard MUST Modified Composite

SECTION IV CHECKLIST

ALL NBQs	SMALL GROUP NBQs	LARGE GROUP NBQs
Schedule of Medical Benefits	# of completed GHS _____	Claims experience, past 24 mos. in 12 mo. periods
Census - Name, DOB, plan choice and tier, class (ie active, retired)		- Total paid claims - Total # employees covered per period - Total # claimants over \$25K and total paid for each - For over \$25K claimants, include de-identified info with diagnostic codes and degree of recovery
Invoice or total month premium		

SECTION V CURRENT PLAN INFORMATION

Benefits Provider: _____ Plan Renewal Date: _____ # of Medical Plan Options: _____

	Deductible	Generic Co-Pay	Preferred Brand Co-Pay	Non-Preferred Brand Co-Pay	Prescriptions Out-of-Pocket Max. (Individual, including Deductible)
Rx:					

	Yes No		Carrier Name	BYtk cf_3 YES NO		Annual Max	Deductible & Services (Type A, Type B, Type C)	Ortho If YES, what age			Yes No		Amount
	YES	NO		YES	NO			YES	NO	YES	NO		
Dental:													
Vision:													



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Rate Information – All current plan options

Medical	PLAN 1		PLAN 2		PLAN 3	
Individual Medical Deductible:						
Co-pay						
Co-insurance (paid by plan)						
Out-of-Pocket Maximum (including deductible) Coverage Tier						
	# of EEs	Rate	# of EEs	Rate	# of EEs	Rate
Employee Only						
Employee + Spouse						
Employee + Child(ren)						
Employee + Family						
Employee Only Retiree						
Employee + Spouse Retiree						
Employee + Family Retiree						
Medicare Single						
Medicare Two Party						
Medicare, 1+/1- Age 65						
Total # of Employees:						
Plan includes Rx?	YES	NO	YES	NO	YES	NO
Plan utilizes office visit co-pay?	YES	NO	YES	NO	YES	NO
HSA-qualified HDHP & Rx accumulates to medical deductible?	YES	NO	YES	NO	YES	NO

Additional Notes:

FOR MUST USE ONLY: Date submitted to actuaries: ___/___/___
 Small group risk determination: _____ Date received: ___/___/___
 Large group work book date received: ___/___/___