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:

☐ Admin ☐ Certified ☐ Classified

With the current carrier can a dependent of a Medicare eligible retiree who drops their coverage continue on their own plan?

☐ Yes ☐ No

☐ Deductible Credit Requested

SECTION III — MUST QUOTE

Plans Quoting: _____

Tiers: ☐ Standard MUST ☐ Modified ☐ Composite

SECTION IV — CHECKLIST

ALL NBQs

☐ Schedule of Medical Benefits

☐ Census - Name, DOB for all members, plan choice and tier, class (ie active, retired)

☐ Historical Census if available

SMALL GROUP NBQs

☐ # of completed GHS

_____

LARGE GROUP NBQs

☐ Claims experience, past 24 mos. in 12 mo. periods

- Total paid claims, including pharmacy
- 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

SECTION V — CURRENT PLAN INFORMATION

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

# of years with current provider

	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	Network? YES	Network? NO	Annual Max	Deductible & Services (Type A, Type B, Type C)	Ortho YES	Ortho If YES, what age	Ortho NO
Dental:										

	Yes	No	Carrier Name	Exam Frequency	Lens Benefit	Materials Benefit
Vision:						

	Yes	No	Amount
Basic Group Life:			

	Yes	No	% Pre-Disability Earnings	Monthly Max	Elimination Period
LTD:					

# of years with current provider Dental _____ Vision _____

NEW BUSINESS QUOTE

MONTANA UNIFIED SCHOOL TRUST

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: ___/____/___