

1. Producer information

Agency name: _____ Contact name: _____

Phone number: _____ Email: _____ Date submitted: _____

Are you the current producer of record for medical and pharmacy? Yes No

If no, state your relationship to the group: _____

Commission requested (if 100+): _____

2. Employer group information

Employer group name: _____

Address: _____

City: _____ State: _____ ZIP code: _____ County: _____

Contact name: _____ Email: _____

Phone: _____ Fax: _____

No. of employees: _____ No. of out-of-area employees: _____ SIC code: _____ Industry: _____

Current carrier: _____ Current plans: _____

Years with current carrier: _____ Renewal date: _____ Requested effective date: _____

Are you including benefit grids? Yes No Does the employer fund an HRA? Yes No

If yes, how much funding and when (%/first/last)? _____

Does the employer have workers' compensation? Yes No

Does the employer offer dental insurance? Yes No If yes, carrier name: _____

Does the employer offer vision coverage? Yes No If yes, carrier name: _____

Has the employer been in business for at least three months? Yes No

Does the employer have union employees? Yes, name: _____ No

Does the employer purchase benefits through an association? Yes, name: _____ No

Is the employer a former UPMC Health Plan client? Yes, list when: _____ No

Reason employer is out for bid: Cost Network Benefit designs Customer service Health care management

Requested funding arrangement Fully Insured ASO fee Self-Assured Level Funded ASO & Stop Loss

3. Medical premium/claims information

For groups with more than 100 eligible employees, provide monthly experience data for 12 to 36 months. Include separate medical/pharmacy claims, monthly enrollment, and large claims over \$25,000 by experience period with diagnosis and prognosis.

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution (\$ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

4. Dental premium/claims information

For groups with more than 100 eligible employees, provide monthly experience data for 12 to 36 months.

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution (\$ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

5. Vision premium/claims information

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution (\$ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

6. Census information

Attach a complete census that includes name, date of birth, gender, coverage tier, ZIP code, and current plan option (if multiple plans are offered) for each eligible employee. All eligible employees must be included, even if they are waiving coverage. Clearly identify out-of-area employees.

7. Product information

Indicate specific UPMC Health Plan products that are being requested.

Rx plan:	PPO:	EPO:	UPMC HealthyU:
HRA:	HSA:	Out of Area:	Other:
Dental:	Vision:		

UPMC HEALTH PLAN

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

