Rate Request Form

For employer groups with 51+ employees

1. Producer information

Agency name: ______________________________ Contact name: ______________________

Phone number: ______________ Email address: ______________________ 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 address: ______________________________

Phone number: ______________________ Fax number: ______________________

Number of employees: ______ Number 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

Notes:

UPMC Health Plan

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. If applicable, include the coverage tier and current plan option for dental and vision coverage. **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:		

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