COLLABORATIVE HEALTHCARE INSURANCE PROGRAM

2017-2018 RFP FORM

Name of the Group:

Corporate Address:

Total number of Benefit Eligible Employees:

Total number of Enrolled Employees:

Total number of Plans Currently Offered:

Current Carrier:

Natural Renewal Date:

Proposed Effective Date:

Current Annualized Premium:

Is Claims Data Available?

Are there any known Large Claims?
(If yes, please provide details)

So you plan to pre-underwrite the quote?

(If yes, then either claims data or the attached medical questionnaire will need to be completed for each enrolled employee and their enrolled dependents)

Note that if you do not pre-underwrite the case, then all rates released will be subject to final underwriting and enrollment.

Agency Contact:

Email Address:

Phone number:

Please also provide the following:

- Census (including name, date of birth, gender, enrollment tier, home zip code)
- Copy of the most current carrier invoice
- Outline of current plan designs

COLLABORATIVE HEALTHCARE
INSURANCE
TRANSFORMING THE INDUSTRY