



GROUP HEALTH INSURANCE – REQUEST FOR PROPOSAL

Section 1: Employer Information			
Legal Company Name		Nature of Business/Web address	
Mailing Address/Physical Address (if different)		City	State
			Zip
Contact Person	Contact's email address	Phone Number	
List any affiliates or businesses under this employer's common control if applicable.	Is Your Company Registered with the Montana Secretary of State? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Tax ID#		
Section 2: Participation			
1. What is the employer contribution toward employee premium? (min of 50% is required) _____ % Dependents (not required) _____ %			
2. What are the minimum hours worked weekly to be eligible for coverage? (minimum of 20 hours) _____			
3. What is the Waiting Period* for new employees? (*To satisfy the Waiting Period(s), an eligible employee must be employed by the employer and actively at work for the number of hours per month required for eligibility, without break in active employment, for the entire Waiting Period.)			
First day of the month following: <input type="checkbox"/> Employee's Hire Date <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other – please specify			
An eligible employee is one who meets the minimum hourly requirements, and has satisfied the waiting period set by the employer as stated above. Those not meeting requirements are considered not eligible .			
4. What is the total number of employee's you employ? _____ How many of those employee's are eligible for health coverage? _____			
5. Do you have any employee's that live out of the state of Montana <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the zip codes for those employees on the census.			
Section 3: Employer Signature/Statement		Section 4: Broker/Agent Statement	
As the employer or the legally authorized representative of the employer, I certify that all information provided for coverage by Allegiance Life & Health Insurance Company, Inc. is accurate and complete to the best of my knowledge.		I certify that all of the information contained in this RFP and attached paper(s) is (are) correct to the best of my knowledge. I have complied with all of the submission rules and have explained the coverage fully and informed the group to submit all changes in writing to AL&H.	
_____	_____	_____	_____
Signature/Title	Date	Signature	Date



Broker Quote Request

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR A COMPLETE AL&H QUOTE

Attach a census of all ELIGIBLE Employees (Name, DOB, Zip Code, and coverage code - EE,ES,EC,EF or Waive Coverage – Other Coverage?)

1. Group Name		Monthly Premiums				
2. Current Carrier		Current Rates		Renewal Rates		
If Age Rated, what is the Monthly Total - \$		EE		EE		
3. Requested Effective Date		Quote Due Date		ES		
4. Commissions <input type="checkbox"/> Standard 5% <input type="checkbox"/> Other		EC		EC		
5. SIC code (business industry code, if applicable)		EF		EF		
6. Benefit Period -if one is not selected plan year will be the option quoted.		ES+1				
7.. <input type="checkbox"/> Plan Year (e.g. June-July)		<input type="checkbox"/> Calendar Year (Jan-Dec) If Calendar year – is deductible credit requested <input type="checkbox"/> Yes <input type="checkbox"/> No		ES+2		
8. Plan options may be <u>either</u> a PPO plan <u>or</u> a HDHP/HSA option. Please choose 3 options. Use the columns as your guide to the benefits that are available for both the PPO and HDHP/HSA plans, some restrictions apply and some plan choices may not be valid options.						
Benefit Description	Plan Option 1		Plan Option 2		Plan Option 3	
	PPO	OR HDHP/HSA	PPO	OR HDHP/HSA	PPO	OR HDHP/HSA
Deductible per Insured. PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> \$3,300/\$6,600 <input type="checkbox"/> \$4,000/\$8,000 <input type="checkbox"/> \$5,000/\$10,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> \$3,300/\$6,600 <input type="checkbox"/> \$4,000/\$8,000 <input type="checkbox"/> \$5,000/\$10,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> \$3,300/\$6,600 <input type="checkbox"/> \$4,000/\$8,000 <input type="checkbox"/> \$5,000/\$10,000
Deductible per covered family. PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional – Benefits payable after Single deductible is met (embedded) <input type="checkbox"/> HDHP-Benefits payable after Individual <i>Deductible</i> is met for Employee only coverage. Benefits payable after Family <i>Deductible</i> is met for Family Coverage. (non-embedded)	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional – Benefits payable after Single deductible is met (embedded) <input type="checkbox"/> HDHP-Benefits payable after Individual <i>Deductible</i> is met for Employee only coverage. Benefits payable after Family <i>Deductible</i> is met for Family Coverage. (non-embedded)	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional – Benefits payable after Single deductible is met (embedded) <input type="checkbox"/> HDHP-Benefits payable after Individual <i>Deductible</i> is met for Employee only coverage. Benefits payable after Family <i>Deductible</i> is met for Family Coverage. (non-embedded)
Out-of-Pocket Maximum. PPO Out-of-Pocket Maximum does not apply toward Non-PPO Out-of-Pocket Maximum. Non-PPO Out-of-Pocket Maximum does not apply toward PPO Out-of-Pocket Maximum.	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> N/A –plan pays upon satisfaction of deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> N/A –plan pays upon satisfaction of deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> N/A –plan pays upon satisfaction of deductible

Group Name:	Plan Option 1 cont...		Plan Option 2 cont...		Plan Option 3 cont...	
Out-of-Pocket Maximum per covered family.	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional <input type="checkbox"/> HDHP	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional <input type="checkbox"/> HDHP	<input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> HDHP	<input type="checkbox"/> Traditional <input type="checkbox"/> HDHP
Co-pay for Provider office visit.	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> N/A	N/A	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> N/A	N/A	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> N/A	N/A
Benefit Percentage of the Maximum Eligible Expense ("MEE") that the Policy pays. It pays for covered services after the deductible. It pays the percentage selected up to the out-of-pocket maximum. Then it pays 100% of covered charges.	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%	<input type="checkbox"/> 50/50% <input type="checkbox"/> 60/40% <input type="checkbox"/> 70/30% <input type="checkbox"/> 80/20% <input type="checkbox"/> 90/10% <input type="checkbox"/> 100%
Optional preventive services.	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	<input type="checkbox"/> None <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
Supplemental Accident (\$500 per accident)	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Lifetime Maximum	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Prescription Benefit Rx 1 -\$5/\$20/\$40 Rx 2 -\$10/\$30/\$60 Rx 3 -\$20 or 20% co-pay Rx 4- Drug Card – only available with HSA qualified plans	<input type="checkbox"/> Rx 1 <input type="checkbox"/> Rx 2 <input type="checkbox"/> Rx 3 <input type="checkbox"/> Rx 4	<input type="checkbox"/> Rx 4	<input type="checkbox"/> Rx 1 <input type="checkbox"/> Rx 2 <input type="checkbox"/> Rx 3 <input type="checkbox"/> Rx 4	<input type="checkbox"/> Rx 4	<input type="checkbox"/> Rx 1 <input type="checkbox"/> Rx 2 <input type="checkbox"/> Rx 3 <input type="checkbox"/> Rx 4	<input type="checkbox"/> Rx 4
RX Deductible – per benefit period/per Insured	<input type="checkbox"/> None <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	N/A	<input type="checkbox"/> None <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	N/A	<input type="checkbox"/> None <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500	N/A
Dental Quote			COBRA – Is your group eligible?			
Deductible – per person	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100		<p>Some employers may be required to provide COBRA continuation coverage for employees and their covered dependents. An Employer is exempt from federal COBRA continuation coverage requirements if the Employer employed less than 20 employees for 50% or more of its regular work days for the calendar year immediately before the current calendar year. Employees means all common law employees (full-time and part-time and leased) as defined by Section 414(n) of the Internal Revenue Code</p> <p>1. COBRA eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Allegiance Life & Health Company, Inc. will administer COBRA for your group, this is included within the quoted rates.</p>			
Preventive/ Diagnostic (A)	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% -deduct waived for A					
Basic (B)	<input type="checkbox"/> 60% <input type="checkbox"/> 70% <input type="checkbox"/> 80%					
Major (C)	<input type="checkbox"/> 50% <input type="checkbox"/> 60%					
Annual Maximum	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000					
Orthodontia Benefit	<input type="checkbox"/> None <input type="checkbox"/> Policy pays 50% after deductible					
Orthodontia Maximum	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000					
Vision – will be provided with all quotes.						



Group Name: _____

Complete the following Census for all Eligible Employees or provide a copy of an electronic census with the following information. Groups with 20+ eligible employees please send an electronic census (e.g. Excel spreadsheet).

An **eligible employee** is one who meets the minimum hourly requirements, and has satisfied the waiting period set by the employer as stated above. Those **not** meeting requirements are considered **not eligible**.

Coverage Codes - **EE**-Eligible Employee **ES** – Employee/Spouse **EC**-Employee/Child(ren) **EF**-Employee/Family **WC**-Waive Coverage
 If Waiving Coverage – indicate whether employee has **Other Coverage**

Employee Name (Last Name, First Name, MI)	Date of Birth (mm/dd/yy)	Coverage Code	Date of Hire (mm/dd/yy)	Number of hours worked per week	State of Residence (complete if not MT)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

I have provided a complete and accurate list of all employees who have met the requirements and are eligible for health coverage under this group policy.
 Signature of Group Leader _____ Date _____