BlueCross BlueShield of Oklahoma
Experience. Wellness. Everywhere.®

Request for Proposal (Small Group 2-50)

Return via email to BlueQuote@bcbsok.com or via fax to (918) 549-3200.

Producer/Agency Name:	Producer/Agency #:
Producer/Agency Phone #:	Send proposal to the following email:
Business Name (and DBA, if applicable):	Requested Effective Date
Physical Address of Business (include ZIP code, no P.O. box):code, no P.O. box):	Standard Industry Code (SIC, 4 digit):

Rate Proposal – Our rate proposal will include health plans, dental plans, vision plans (for groups with 10+ enrolling employees), and life/disability coverage.

2 Eligible, 1 Enrolling Employee (resulting in 1 contract) – Each employee must complete a Small Business Enrollment Application/Change Form which includes a statement of health.

2-50 Enrolling Employees (resulting in 2+ contracts) – A company representative must complete a Group Employer Medical Questionnaire. A complete census is also required.

Name of Current Health Care Carrier:

Employee Count

_____ Total employees on payroll
+_____ New hires not yet on payroll
- _____ Part-time employees working fewer than 24 hours per week or other part-time staff to whom the employer is not offering coverage
- _____ Seasonal and temporary employees
- _____ Terminated employees

=_____ Total employee count

NOTE: If the result is between two and 50, the employer is a candidate for small group coverage.

Life, AD&D:

- ☐ $10,000
- ☐ $15,000
- ☐ $20,000
- ☐ $30,000 (default)
- ☐ Other amount, please specify:_____

Life, AD&D:

- ☐ Percentage of Salary: _____%
  (Please include salary for each employee provided on the census)
- ☐ Dependent Life
- ☐ Voluntary Life

Important Information for groups with 2-9 enrolling employees

Monthly premium amounts can be provided for each eligible employee listed on the census. You may request specific benefit plans to include this level of detail.
Specify up to 5 plan name(s) below. Examples: RYB409 or RW485.

_____, _____, _____, _____, _____.

Disability:

- ☐ STD (default $200 weekly)
- ☐ LTD
- ☐ Voluntary STD
- ☐ Voluntary LTD

Dental:

- ☐ Voluntary Dental (Group Size: 2+)

Census Information* – can be filled out below or attached

Last Name	First Initial	DOB (mm/dd/yyyy) preferred OR Age (in years)	Gender (M or F)	Coverage Type EO - Emp. EC - Emp.+Ch ES - Emp.+Sp EF - Emp. +Fam	No. of Children	Home ZIP (5 digits only)	Employment Status (FT, PT, Seasonal, Temp, Terminated)	Salary Life Only

***For 2-9 enrolling employees, DOB preferred for all dependents applying for coverage.** Spouse and children birthdates allow us to provide more accurate rates.