

Idaho Proposal Request		Today's Date:	Proposal Effective Date:	Proposal Deadline:
Group/Employer Name:		Address:	City	State
			Zip	County
Agent Name:		Coverage Requested: <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> HRA <input type="checkbox"/> FSA Other: _____		
Agency Contact/Admin :		Group Size: <input type="checkbox"/> Small (2-50 Employees) <input type="checkbox"/> Large (51+ Employees) <input type="checkbox"/> Standalone Dental (10+ Enrolled Employees)		
Agency Phone:		Years in Business / Inception Date:	Any Other Affiliates or Subsidiaries:	Industry (SIC, if known):
Agency Fax:		Will PacificSource be the only health carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Qualification Period (days) – First of month following: <input type="checkbox"/> DOH <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days	
Agency Contact Email Address:		Number of Health Carriers in Last 5 Years?	Carveout:	
Total Number of Active Employees:		Minimum Hours per Week to Be Eligible: (30 hour max groups under 50)	Minimum Employer Contribution: (75%0% minimum groups under 50) Medical: / Dental: /	
Ineligible Employees	-	MEDICAL – Current Carrier _____ Renewal Date _____ Deductible _____ OOP _____ Coinsurance _____ Office Copay _____ Other _____		
Total Eligible	=	Current Medical/Rx Rates: EE: _____ ES: _____ EF: _____ EC: _____ Renewal Medical/Rx Rates: EE: _____ ES: _____ EF: _____ EC: _____		
Waiving to Other Qualifying Coverage:	-	Quote: Deductible: _____ OOP: _____ Coinsurance: _____ Office Copay: _____ Other: _____	Quote: Deductible: _____ OOP: _____ Coinsurance: _____ Office Copay: _____ Other: _____	Quote: Deductible: _____ OOP: _____ Coinsurance: _____ Office Copay: _____ Other: _____
Waiving Coverage for Other Reasons: Cannot exceed 10% of eligible employees	-	Prescription: Generic/Prefered/ Nonprefered: _____/_____/_____	Prescription: Generic/Prefered/ Nonprefered: _____/_____/_____	Prescription: Generic/Prefered/ Nonprefered: _____/_____/_____
Total Cobra:	+	Dental: Deductible: _____ Annual Max: _____ Design: _____	Dental: Deductible: _____ Annual Max: _____ Design: _____	Dental: Deductible: _____ Annual Max: _____ Design: _____
Total Retirees:	+			
Total Enrolling:	=			
Probationary employees, eligible within 3 months. <i>Applications required to quote.</i>	+			
TOTAL APPLICATIONS INCLUDED	=			
Enrolling Out-Of-State Employees—Total:		DENTAL - Current Carrier _____ Renewal Date _____		
#Emps	City, State, and/or Zip	Deductible _____ OOP _____ Coinsurance _____ Office Copay _____ Other _____		
		Current Dental Rates: EE: _____ ES: _____ EF: _____ EC: _____		
		Renewal Dental Rates: EE: _____ ES: _____ EF: _____ EC: _____		
		Complete this section only if group has 51 or more eligible employees:		
		Has any employee been absent from work for more than 5 days during the past month due to illness or injury? Yes No		
		If yes, explanation and status: _____		
		Is any employee or dependent currently undergoing treatment for a Workers' Compensation injury, or had a Workers' Compensation claim exceeding \$5,000 in the past five years? Yes No		
		If yes, explanation and status: _____		
For Internal Use Only:		Complete this section only if group has 100 or more enrolled employees:		
Date Received	Date Out	Claims experience required if group has 100+ employees, or any size group if self-funded.		
	Keyed	Please list desired commission: _____ (% , PEPM, or PMPM)		
	Client Number	If 200+ employees enrolling, is quote to match current benefits? Yes No If yes, attach benefit handbook.		