LARGE GROUP PROPOSAL REQUEST CHECKLIST

Date Submitted: _____

Proposed Effective Date: _____ **Current Carrier:** _____

Broker Name:			
Agency Name:			
Address:			
Telephone:	( ) -	**Fax:**	( ) -

Client Name:			
Contact Name:			
Address:			
Telephone:	( ) -	**Fax:**	( ) -

Description of Business (include S.I.C. Code):	

☐ **COPY OF CURRENT PLAN AND SUGGESTED OR DESIRED CHANGES.**

☐ CURRENT CENSUS INCLUDING EMPLOYEE BIRTHDATE, DATE OF HIRE, ELIGIBILITY DATE AND STATUS (SINGLE / FAMILY)

☐ 3-YEAR AGGREGATE REPORTS (SELF-FUNDED PLANS)

☐ 3-YEAR PREMIUM HISTORY AND CURRENT RENEWAL RATES (FULLY INSURED)

☐ COMPLETED COBRA / DISABLED EMPLOYEE DISCLOSURE

☐ COMPLETED SHOCK LOSS CLAIMANT DISCLOSURE (DISCLOSE ALL CLAIMANTS WITH CLAIMS OVER $5,000)

☐ DETAILS REGARDING ANY CLAIM (REGARDLESS OF COST) WHICH INVOLVES ANY ONE OF THE FOLLOWING DIAGNOSES:

* AIDS
* Amputations
* Serious Burns
* Cancer
* Any Hospitalization of One Month or More
* Multiple or Serious Fractures
* Head Trauma
* Premature Births
* Serious Psychoneurosis Impairment
* Organ Transplants
* Artificial Implants (either proposed or ongoing)
* Spinal Cord Injuries
* Crushing or Massive Internal Injuries
* Heart Disease
* Coronary Bypasses

SUBMITTED BY: _____ **DATE:** _____

COBRA PARTICIPANTS
List all plan participants currently on COBRA. (Use additional sheet if necessary.)

Name	EE or Dep	S/F Cov	COBRA eff. date	COBRA Term date	Qualifying Event

Disabled Participants:
List all plan participants who are disabled. A disabled participant includes any dependent unable to perform usual life activities (work, school, etc.) (Use additional sheet if necessary.)

Name	Diagnosis	Prognosis

Shock Losses:
List any claimant at, or who will reach, $5,000 in incurred claims. (Attach additional sheets if necessary.)

Patient Name:	Relationship to Insured: (Self/Spouse/Dependent)	Amount of Claim: $
Diagnosis / Prognosis:		
Patient Name:	Relationship to Insured: (Self/Spouse/Dependent)	Amount of Claim: $
Diagnosis / Prognosis:		
Patient Name:	Relationship to Insured: (Self/Spouse/Dependent)	Amount of Claim: $
Diagnosis / Prognosis:		

SECTION A

Group Name: _____ Date Completed: _____
Address: _____ Effective Date Requested: _____
_____ Completed By: _____
Phone: ( ) _____ Title: _____

SECTION B **YES NO**

Has any applicant or covered dependent:

1. Had problems or been treated for any of the following? (Circle all that apply and explain below) Alcoholism/Drug Addiction, Arthritis, Birth Defects, Blood Disease, Cancer, Diabetes, Digestive System, Colitis, Heart, Infertility, Kidney/Urinary, Liver, Lung, Mental/Emotional, Nervous System, Muscular Sexually Transmitted Disease/AIDS, or Stroke/Brain? ( ) ( )
2. Experienced any other serious deformities, symptoms or problems not listed above or aware of any Such conditions existing? ( ) ( )
3. Incurred medical expenses of $5,000 or more, or are they anticipating such medical costs now or in The future? ( ) ( )
4. Been prevented by disability or other health condition from performing usual job activities on More than four occasions or for a total of more than two weeks? ( ) ( )
5. Received or anticipate receiving any kind of transplant? ( ) ( )

SECTION C

For any item in Section B checked "Yes", complete the following:

List Item #	List Applicant or Dependent Name, Age, and Sex	List Problem, Treatment and Degree of Recovery	Dates of Care First / Last	Cost of Care
_____	_____	_____	_____ /	_____
_____	_____	_____	_____ /	_____
_____	_____	_____	_____ /	_____
_____	_____	_____	_____ /	_____
_____	_____	_____	_____ /	_____
_____	_____	_____	_____ /	_____

SECTION D

List any applicant or dependent who is currently pregnant:

List applicant or dependent name: First / Last	List any known or Anticipated Abnormalities (Twins, Premature Birth, C-Section, Etc.)	Age:	Due Date: MM / YY
_____	_____	_____	_____ /
_____	_____	_____	_____ /
_____	_____	_____	_____ /
_____	_____	_____	_____ /

I / We certify to the best of my / our knowledge that the above information is true, complete and accurate.

_____ _____ _____ _____
Signature: **Date:** **Signature:** **Date:**