BlueCross BlueShield of Texas

Mid-Market Request for Proposal

Please complete this entire RFP (2 pages) and submit it to: **TexasRFP51100@bcbstx.com**

Group Information

Legal Group Name _____

EIN _____ SIC _____ Requested Effective Date _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

Name of current and prior carriers for the past three years. Include coverage dates with years: MM/DD/YY - MM/DD/YY

_____

_____

_____

Producer Information

Producer Name _____

Producer Email _____

BCBSTX Assigned Producer Number (9 digits) _____ Current agent? ☐ Yes ☐ No

Make sure you have access to this producer number in BAP as it will be needed to be used to enroll the group should it sell.

PCPM medical commissions dollar amount ($30 is default) _____

General Agent Information (if applicable)

General Agent Name _____

General Agent Email _____

BCBSTX Assigned General Agent Number _____

Note to General Agent: Producer Information section must be completed in full along with General Agent Information section.

Experience Questions (If you answer "YES" to any question, please provide details.)

	YES	NO
In the past 12 months, have any claims over $10,000 been submitted?	☐	☐
Are any treatments that may cost or exceed $10,000 expected within the next 12 months?	☐	☐
Are any participants disabled or not actively at work?	☐	☐
Has any participant been diagnosed with a high risk condition?	☐	☐

Examples: Cancer, heart-related problems, AIDS, drug abuse, mental & nervous conditions

Details_____

_____

Eligibility

Total on Payroll_____

(Plus) COBRA _____

(Plus) Retirees _____

(Minus) Part-time_____

(Minus) Employees in waiting period _____

(Minus) Waiving due to other coverage_____

(Minus) Waiving due to cost_____

= Total Enrolled _____

Length of Waiting Period (0, 30, or 60 days)_____ Employer Contribution ($ or %) _____

Please submit the following with this form:

1. Current Rates
2. Renewal Rates
3. Current Summary of Benefits (SBCs)
4. Premium vs Claims and/or Aggregate report (24 months, if less than 24 months please explain)
5. Large Claims Report 24 months (Must be same time frame as PVC or Agg report)
6. Full member-level census in required excel template:
   - All eligible enrolling employees
   - Employee first and last name, DOB, gender, state, residential ZIP code
   - Coverage level (EO, ES, EC or EF)
   - List enrolling dependents' first and last names, DOB and relationship to employee below subscriber (spouse or child)
   - Include COBRA and/or retirees, if applicable