

INNOVATIVE HEALTH PLAN QUOTE REQUEST FORM



BROKER INFORMATION

Contact Names	Phone	Email
Primary		
Secondary		
Date Proposal Needed:		Requested Commission: %

OPPORTUNITY INFORMATION

Requested Effective Date:		
Company Name	SIC	
Street Address		
City	State	Zip
Other Locations by State		

For a **Quote**, please provide the following:

Census:

- Completed Excel spreadsheet – all groups

Plan of Benefits

- Copy of current medical plan descriptions
- Identify any benefit changes over past three (3) years
- Identify any changes planned for your current renewal

Rate History

- 3 years of rate history, including average enrollment for each period
- Copies of past 3 renewal letters, and current renewal letter if available
- Employer contribution

Claims History - 50+groups

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|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> 3 years of claims loss history <input type="checkbox"/> Completed large claim report <input type="checkbox"/> Any/all carrier reports <input type="checkbox"/> ICD-Reports (if self-funded) | <ul style="list-style-type: none"> <input type="checkbox"/> Individual claim detail report (if self-funded) <input type="checkbox"/> Inpatient report (if self-funded) <input type="checkbox"/> Pended / Denied claims (if self-funded) |
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If unable to provide the above information, the following is required.

- Employer Medical Disclosure form
- Individual Medical Disclosure form for each employee