Large Group New Business Information

GENERAL INFORMATION

Group's Legal Name_____

Group's Headquarters (Street Address or Suite#)_____

City_____ State_____ ZIP_____ County_____

Standard Industry Code (SIC)_____ Agency Name_____

Please indicate the Group's 5500 Plan Year_____

Do any of the following apply to the group?

Union?	☐ Yes	☐ No	If yes, please provide the contract expiration date _____/_____/_____
Retiree Plan?	☐ Yes	☐ No	
ERISA (Self-Funded)	☐ Yes	☐ No	
Benefit Grandfathering	☐ Yes	☐ No	

CARRIER HISTORY INFORMATION

Does this group currently have medical insurance coverage?

☐ Yes (please provide carrier history below)
☐ No (please contact Wellmark to determine required information to quote)

Has group been previously enrolled with another carrier that has used reference based pricing?

☐ Yes
☐ No

Has group been previously enrolled with Wellmark, Inc. or any of Wellmark's subsidiaries under current group name or a different group name?

☐ Yes, please provide group name_____
☐ No

Name of Carrier / Stop Loss Carrier	Dates of Coverage	Funding Arrangement	
	/ / - / /	☐ Fully Insured Levels Current Pooling: $_____	☐ Self-Funded Levels Ind. Stop Loss: $_____ Agg. Stop Loss: % _____ Contract Terms: _____
	/ / - / /	☐ Fully Insured	☐ Self-Funded
	/ / - / /	☐ Fully Insured	☐ Self-Funded

RATE INFORMATION

Please indicate current and renewal rates on the group's most popular plan (based on contracts). FI: actual rates, SF: attachment points

	Dates of Coverage	Single	Family	Employee/Spouse	Employee/Child(ren)
Current	/ / - / /	$	$	$	$
Renewal	/ / - / /	$	$	$	$

For self-funded, stop loss fees (if applicable): Individual Stop Loss Fee: $_____

Aggregate Stop Loss Fee: $_____

ENROLLMENT INFORMATION

Average Number of Employees Employed on Business Days in the Preceding Calendar Year_____

Number of Enrolled Employees_____

EVALUATION INFORMATION

For Indian tribe/tribal organizations:

If you are requesting a self-funded health plan, will the plan be funded whole or in part by an Indian tribe or tribal organization?

☐ Yes, Wellmark is unable to provide a self-funded quote ☐ No, attestation required

Risk Considerations:

Wellmark Blue Cross and Blue Shield uses an experience-based rating methodology that evaluates claims experience and enrollment information to determine rates. In addition to a group's claims experience, medical conditions/information derived from the following questions will be used to assist the underwriter in evaluating the risk.

Please indicate any individuals (including those not actively at work) who are currently receiving, have received, or are pending medical management for any of the following conditions or treatments: ☐ None/not aware

☐ AIDS/HIV
☐ High Risk Pregnancy
☐ Immune Deficiency
☐ Malignant Neoplasm (cancer)
☐ Hemophilia
☐ Neurological Disease
☐ Respiratory Condition
☐ Disability/Handicapped
☐ Blood Disorders
☐ Cardiac/Coronary Disease
☐ Chronic Renal Failure

☐ Hospitalization
☐ Home/Facility Confinement
☐ Nursing Facility
☐ Neonatal Care
☐ Surgery
☐ Transplant

For each condition/treatment checked above, please indicate the following information:

Age	Gender	Name of Condition(s)	Current Prognosis/Medications	Last Treatment	Total Claims ($) (recent 12 months)
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	

DOCUMENTATION FOR QUOTING (SEE ADDITIONAL INFORMATION, BASED ON FUNDING ARRANGEMENT):

- Current Census in Excel Format
  - Include age, gender, type of coverage, zip code and benefit plan (if more than one offered). See preferred Wellmark Census Template (N-2328 9/13).
- Claims Experience (medical & pharmacy)
  - Minimum of 24 months and within 6 months of the requested effective date. Month-by-month or two 12 month time periods.
  - If group is under 100 enrolled, is currently fully insured and claims data is not available: a minimum of 2 years premium history is required.
- Enrollment Matching Claims Experience Periods
- Large Claims Matching Claims Experience Periods
  - Large claimant data ($ minimum) is based on funding arrangement. See table below.
  - Claims exceeding $100,000 or any medical condition of a catastrophic nature to include one of the following: a) case management notes, b) detailed claims listing including date of service, diagnosis and procedure codes, or c) APS (Attending Physician Statement).
- Legal Documentation
  - When covering more than one group, proof of common ownership or merger/acquisition documentation is required.

Additional documentation when quoting **Fully Insured** funding arrangement:	Additional documentation when quoting **Self-Funded** funding arrangement:

• Benefit Summaries or SBC's Matching Claims Experience
  • If benefits have changed in the past 3 years, please attach previous benefits summaries matching claims experience.
• Claims exceeding $10,000 Matching Claims Experience
  • Need diagnosis, claim(s) amount and enrollment status.
	• SPD's or SBC's
	  • If benefits have changed in the past 3 years, please attach previous SPD's or SBC's matching claims experience. If group is currently fully insured, SPD is not required.
	• Claims exceeding 50% of individual stop loss deductible (or current pooling level) matching claims experience
	  • Need diagnosis, claim(s) amount and enrollment status.
	• 2-years lag report (if quoting run-in)

By signing this form, we certify that we are authorized to sign on behalf of the above referenced group and that, after this form was completed, we carefully and fully read it, that the statements and answers set forth are full, true and correct to the best of our knowledge and belief, and that no information required to be given either expressly or by implication, has been knowingly withheld. We understand Wellmark will rely upon the completeness and truthfulness of the information given and the statements made, and that if we have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will seek redress to the full extent permitted by applicable law.

Employer Signature:_____ Date _____/_____/_____

Title_____

Consultant Signature:_____ Date _____/_____/_____

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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