MediExcel HEALTH PLAN

REQUEST FOR PROPOSAL FORM
SMALL GROUPS (1-100 EMPLOYEES)

BROKER INFORMATION

BROKER NAME

AGENCY NAME

PHONE FAX

ADDRESS CITY / ZIP

E-MAIL

BROKER LICENSE NUMBER

COMMISSION REQUESTED

BROKER OF RECORD? ☐ YES ☐ NO

REASON FOR SHOPPING:

☐ REDUCING COSTS ☐ IMPROVE BENEFITS

☐ MARKET CHECK ☐ OTHER _____

HOW DID YOU HEAR ABOUT US?

BUSINESS/GROUP INFORMATION

COMPANY NAME

DBA

EFFECTIVE DATE REQUESTED PROPOSAL DUE DATE

NATURE OF BUSINESS

DOES THE GROUP OFFER CROSS-BORDER INSURANCE?

☐ YES (PLEASE IDENTIFY IN CENSUS) ☐ NO

CURRENT CARRIER(S) *(PLEASE ATTACH RENEWAL RATES)*

MEDICAL: _____

DENTAL: _____

VISION: _____

OF ELIGIBLE EE'S_____ # OF ENROLLED EE'S_____

ELIGIBLE EMPLOYEES ARE PERMANENT, ACTIVE, FULL-TIME EMPLOYEES WORKING A MINIMUM OF 30 HOURS PER WEEK. THE FOLLOWING CLASSIFICATIONS ARE NOT ELIGIBLE:

EMPLOYEES WORKING LESS THAN 30 HOURS PER WEEK, LEASED EMPLOYEES, SEASONAL EMPLOYEES, 1099, UNION, BOARD MEMBERS, RETIREES, COBRA PARTICIPANTS OR SURVIVING SPOUSES.

EMPLOYER MEDICAL CONTRIBUTION FOR **EMPLOYEE**:_____% OR $_____

EMPLOYER MEDICAL CONTRIBUTION FOR **DEPENDENTS**:_____% OR $_____

MediExcel Health Plan is an environmentally conscious organization that takes great pride in reducing paper waste. By completing this form, you acknowledge that all Plan documents, including invoices will be sent to you via e-mail.

Please send client's **Billing Contact's** information and **E-mail Address** to **billing@mediexcel.com**.

NRM 061519

Please return completed form along with census and current carrier rates to: rfp@mediexcel.com