Minnesota Health Care Consortium – Request for Proposal Information

SECTION **A** | **MHC REQUEST FOR PROPOSAL INFORMATION**

Name of Group			
Group Address (Must be a physical address, no P.O. Boxes)			
Street			
City	State	ZIP Code	County
Group Contact(s)		Title	
Phone Number		Email Address	
Group Tax ID			
Requested Effective Date ____ / ____ / _____		Proposal Due Date ____ / ____ / _____	
☐ School ☐ City ☐ County ☐ Other Government Agency ☐ (specify and attach ERISA Exempt Form)			
History with Minnesota Healthcare Consortium/Service Cooperatives ☐ Yes ☐ No			
If yes please describe dates and region			
Name of Agent /Agency		Current AOR ☐ Yes ☐ No	
Commission **(**Please specify per contract per month or on a percentage basis)			
PSPM		Included on Proposal or Billed Separately?	
Group's Current Carrier		Prior Carrier (if less than 2 years)	
Fully Insured or Self Insured?		Total Current Employees on Insurance	

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Total Employees Working 20+ Hours/Week		
Total Eligible Lives	Are early retirees eligible? ☐ Yes ☐ No	
Employer Contribution	Single	Family
If by class, please specify		
Spending Account Administrator		
☐ VEBA ☐ HSA ☐ HRA ☐ 105 ☐ FSA		
Employer Contribution	Single	Family
If by class, please specify		
Cash or other incentive to employees waiving coverage?		
Submitted by (Print Name)	Date	
Telephone	Email	

Please attach all documents via secure email. If you do not have access to a secure email, please request one. Unsecure documents will not be accepted.