HEALTH PLANS
UNIVERSITY OF UTAH

RFP

GROUP INFORMATION

Requested Effective Date _____ Quote Due Date _____
Company Legal Name _____ DBA Name (if applicable) _____
Company Address _____
Nature of Business _____ SIC/NAICS _____
Full Time Eligible Employees _____ Part-Time Ineligible Employees _____ New Hire Waiting Period _____
Number of Employees on COBRA _____ Does your company meet the definition of large employer? ☐ **Y** ☐ **N**
Do you have employees outside of Utah? ☐ **Y** ☐ **N** if yes, what states do you do business in? _____
Employer Contribution: Employee _____ +Spouse _____ +Child _____ +Children _____ +Family _____
Current Carrier _____ Years with Carrier _____ Self-Funded/Level-Funded ☐ **Y** ☐ **N**
Last Year - Carrier _____ Renewal% _____ Effective Date _____ Plan/Benefit Changes ☐ **Y** ☐ **N**
2 Years Ago - Carrier _____ Renewal% _____ Effective Date _____ Plan/Benefit Changes ☐ **Y** ☐ **N**
3 Years Ago - Carrier _____ Renewal% _____ Effective Date _____ Plan/Benefit Changes ☐ **Y** ☐ **N**

Broker Name _____ Agency Name _____
Commission _____ Phone Number _____ Email Address _____

HEALTH INFORMATION (Please answer the following questions to the best of your knowledge)

A. Has any employee or dependent had problems or been treated for any of the following?

☐ Alcohol Abuse	☐ Cancer/Tumor	☐ Heart Disease	☐ Neurological
☐ Arthritis	☐ Diabetes	☐ Infertility	☐ Pancreas
☐ Back/Neck	☐ Drug Abuse	☐ Intestines	☐ Skin
☐ Blood	☐ Epilepsy	☐ Kidney, Liver, Lungs	☐ Stomach
☐ Bone/Joint	☐ Ears/Nose	☐ Mental Illness	☐ Stoke
☐ Brain	☐ Emphysema	☐ Migraines	☐ STD / AIDS

☐ Other condition requiring surgery, home care, or hospitalization

B. Is any employee or dependent currently pregnant? ☐ **Y** ☐ **N** if yes, when are they due? _____

C. In the past 12 months has any employee or dependent

a. Incurred medical claims over $10,000? ☐ **Y** ☐ **N**
b. Been unable to work because of disability or health conditions for 7 or more days? ☐ **Y** ☐ **N**
c. Had surgery or transplant? ☐ **Y** ☐ **N**
d. Been hospitalized? ☐ **Y** ☐ **N**
e. Been advised they will need surgery, treatment or hospitalization in the next year? ☐ **Y** ☐ **N**

D. If you answered yes to any of the above questions, please provide the following info for each employee or dependent.

Employee or Dependent?	Age	Condition	Date(s) of Treatment	Treatment Required	Future Treatment Required

ITEMS NEEDED TO QUOTE (Please submit your RFP to uuhpsales@utah.edu)

A. Census of all employees (Gender, Date of Birth, Zip Code, Enrollment Tier, Plan Choice.
B. Claims Experience (Past 3 Years).
C. Rates and benefit/plan designs - Current and Renewal
D. High claimants, including paid amount by year, diagnosis and prognosis
E. Recent Billing/Invoice.
F. Top 25 Rx drugs by paid amounts if available.

Completed By _____ Title _____

Signature _____ Date _____