



# Small Group Request for Proposal



Phone 1-888-500-3355 FAX 406-457-2297

## EMPLOYER/PLAN SPONSOR INFORMATION

Name \_\_\_\_\_ DBA (if applicable) \_\_\_\_\_

Address \_\_\_\_\_

Group Tax ID Number \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Agent's Name and Address: \_\_\_\_\_

Organizational Structure:  Sole Proprietorship  Limited Liability Partnership  Limited Liability Corporation  Incorporated  Other: \_\_\_\_\_

Contact \_\_\_\_\_ Contact's Email Address \_\_\_\_\_

Business/Industry Type: \_\_\_\_\_ Is this business registered with the Montana Secretary of State?  Yes  No

Affiliates, if any, included under this Group Contract: \_\_\_\_\_

Affiliates' Address \_\_\_\_\_

For a full quote you must:

- Attach a current Census that is signed and dated by the employer and/or submit a UI-5, if available.
- Attach completed Employee Enrollment/Change Form with Medical History Forms for all employees.

## GENERAL INFORMATION

a. How many total employees do you employ? Full Time \_\_\_\_\_ Part-Time \_\_\_\_\_ How many employees are eligible for health coverage? \_\_\_\_\_

b. Requested effective date of the coverage \_\_\_\_\_ (Subject to Approval by New West Health Services)

c. If applicable, do you want New West to administer COBRA for your New West group members?  Yes  No

d. Employee Participation Requirements: 2 - 5 Employees, 100% participation is required. Over 6 Employees, 75% participation is required.

e. New employees are eligible after a waiting period of (select one):  No Waiting Period  30 Days  60 Days  90 Days  180 Days  
 365 Days  Other - please list (maximum 365 days): \_\_\_\_\_

f. What is the employer contribution? (minimum 60% of Employee Only Rate) Employee: \_\_\_\_\_% Dependents: \_\_\_\_\_%

g. Employees must work a minimum of \_\_\_\_\_ (minimum 20 and maximum 40) hours per week to be eligible for coverage.

h. Are employees eligible to continue coverage under the group plan while they are on an employer-approved reduction of work schedule?  Yes  No  
If Yes, how long (maximum 12 months): \_\_\_\_\_ (New West may, at any time, request a copy of your policy and procedures.)

i. Retirees (Government/Public Entities Only) Do you want coverage for retirees?  Yes  No Do you want coverage for early retirees?  Yes  No  
If you marked Yes, are retirees and early retirees a separate class of employees?  Yes  No If No, they will be treated the same as regular employees for the purpose of this coverage.

j. List any employees or dependents who are under age 65 and covered by Medicare due to disability or end stage renal disease. (Include Name, SSN and Medicare Number. (Attach additional sheets as necessary.)

**NOTE:** Dependent children are allowed to be covered under an employee's policy until they reach the age of 25, and the child will remain on the coverage until the end of the month the child turns age 25 years old.

<b>COVERAGE</b> <ul style="list-style-type: none"> <li>Plans: Select up to 3 products that you would like quoted.</li> <li>Optional Riders: For each plan you selected, choose any optional riders you would also like quoted.</li> </ul>									
<b>Innovations</b>				<b>Prescription Drugs</b>			<b>Dental</b>	<b>Vision</b>	
			10/20/40	15/25/50	20/40/60	Generic Only			
<input type="checkbox"/> 80/500			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 70/1000			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 60/1500			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>New West Select</b>				<b>Prescription Drugs</b>			<b>Dental</b>	<b>Vision</b>	
			10/20/40	15/25/50	20/40/60	Generic Only			
<input type="checkbox"/> 100/5000			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 100/2000-4000 Integrated RX (HSA Eligible)			-	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 100/3000-6000 Integrated RX (HSA Eligible)			-	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 100/5000-10,000 Integrated RX (HSA Eligible)			-	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Health Connections</b>			<b>Copayment Rider</b>		<b>Prescription Drugs</b>			<b>Dental</b>	<b>Vision</b>
			\$30	10/20/40	15/25/50	20/40/60	Generic Only		
<input type="checkbox"/> 90/1000			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 90/2500			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 100/2250			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 100/5000			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 75/500 (Standard Plan)			-	-	-	-	-	-	
NWHP HMO			<b>Point-of-Service Rider</b>		<b>Prescription Drugs</b>			<b>Dental</b>	<b>Vision</b>
			70/1000	60/1000	10/20/40	15/25/50	20/40/60	Generic Only	
<input type="checkbox"/> ValCare			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> ValCare Plus			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Westcare			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Westcare Plus			-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Basic Plan			-	-	-	-	-	-	
<input type="checkbox"/> Uniform Plan			-	-	-	-	-	-	
<b>ACKNOWLEDGEMENT AND SIGNATURE.</b> This request for quote is hereby made for a New West Health Services/New West Health Plan insurance plan. The employer understands and agrees: <ul style="list-style-type: none"> <li>This is a request for a quote only. Issuance of the insurance plan is subject to the Employer/Plan Sponsor completing a Group Contract Acceptance Form (GCAF) and New West Health Services' written acceptance of the GCAF and receipt of the first month's premium.</li> <li>Health coverage must be offered to all full-time eligible employees regardless of health status or any health condition.</li> <li>The employer is responsible for obtaining a waiver of coverage from an employee if the employee or any of the employee's dependents decline coverage.</li> </ul>									
<b>Employer/Plan Sponsor</b>				<b>Agent/Representative</b>					
Signature _____				Signature _____					
Title _____				Title _____					
Date _____				Date _____					