South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

South Carolina Association of CPAs
Request for Proposal

Association Requesting **South Carolina Association of CPA's**
Proposal Producer Requesting **Melissa Shealy**
Proposal Producer Contact #'s **(803) 231-6144** **(888) 751-3201**
Phone FAX

Proposal Producer E-Mail mshealy@mcgriffinsurance.com
Firm Information:
Firm Name _____
Tax ID # _____
Subsidiary/Affiliate Businesses _____
Type of Business _____
Decision Maker Contact & Title _____
Name Title

Billing Contact Name _____ _____
Name Title

Billing Contact _____ _____
E-Mail Phone Number

Address _____ _____ ____ _____
Street City State Zip

_____ _____ ____ _____
PO Box City State Zip

Contact #'s _____ _____
Phone FAX

Employer Premium Contribution $_____or_____% $_____or_____%
Toward Single Cost Toward Dependent

Waiting Period for New Hires _____

Carrier Information: _____
Carrier(s) Name Last 2 Years

Renewal Date _____

Last renewal percent increase _____

REQUIRED

Please attach

1) **Employee census showing all full-time eligible employees of the company requesting the proposal**
   - **Name (last,first)**
   - **Zip code of home address (5 digit)**
   - **Date of birth**
   - **Gender**
   - **Employee or dependent**
   - **Currently enrolled type of coverage (i.e. – single, employee & child, employee & spouse, family, refusal, or within the probationary period)**

Please submit this form and the census to Melissa Shealy, McGriff Insurance Services, mshealy@mcgriffinsurance.com.

For employers over 100 employees and those under 100 that are currently covered by a level-funded or self-funded plan, please provide claims experience. (2 years claims experience and enrollment by month, plus the shock claims information for the same time period)

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Employer Supplemental Information

It is necessary for Blue Cross Blue Shield of South Carolina to obtain certain information in order to issue a proposal for group coverage. Please complete the following to the best of your knowledge.

		YES	NO
1.	Did any employee or dependent suffer a condition which resulted in a claim of $10,000 or more during the last 12 months?	___	___
2.	Are there any employees or dependents who have been or expect to be treated for a serious medical condition?	___	___
3.	Is any dependent child over age 19 incapable of self-support because of a physical or mental disability?	___	___
4.	How many employees and/or dependents are being covered under COBRA continuation? _____		
	To your knowledge, are there any serious medical problems on this group of COBRA continuation insureds?	___	___
	Is anyone presently covered under COBRA totally disabled?	___	___
5.	Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full-time?	___	___
6.	Are any employees or dependents presently disabled? *		
	* For an employee: he or she is absent from work due to injury or illness; * For a dependent: he or she is unable to perform the usual and customary activities of a person of like age and sex in good health.	___	___
7.	Carriers for the last five (5) years and length of time with each carrier:		

_____

_____

If any of the above questions were "YES", please explain below (write the question number and give details):

_____

_____

_____

Employer: _____ Date: _____

Signature of Applicant: _____ Title: _____

Signature of Agent: _____