

## Group Information

Proposed Group Name			
Main Business Address			State CO
			Zip
Current Participation Eligible: _____ Covered: _____		Other Locations	
Current Carrier (Effective Dates)		Prior Carrier (Effective Dates)	<input type="checkbox"/> Association <input type="checkbox"/> PEO <input type="checkbox"/> MEWA
			Carve-Out: <input type="checkbox"/> National <input type="checkbox"/> Management <input type="checkbox"/> Other
Nature of Business			SIC Code

## Proposal Information

Producer Name			
Producer Agency Name		Broker of Record?	How Long?
New Employee Eligibility (1 <sup>st</sup> of Month Following Employment, etc.)	(Minimum Hours Worked)	Employer Contribution for: Employee: _____	Dependents:
Proposed Effective Date	Proposal Deadline Date	Producer Commission <input type="checkbox"/> \$15 Per E/E <input type="checkbox"/> Other: _____	
Currently Self-Funded, Fully-Insured, Other	Reason If Off-Anniversary	Three Year Rate History: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Reason For Proposal Request			
<input checked="" type="checkbox"/> Rates <input type="checkbox"/> Service <input type="checkbox"/> Market Check <input type="checkbox"/> Other :			

## Current Plans & Rates

Current Carrier Name		Effective Date	Renewal Date	Plan Name/Type	Benefits	
					In Network	Out-of-Network
Census	# Enrolled	Beginning Rates	Renewal Rates	PCP Copay		
E/E Only				Specialist Copay		
				Hospital Copay		
E/E + Spouse/ Partner				Deductible-Single		
				Deductible-Family		
E/E + Child or Children				Coinsurance %		
				Out-of-Pocket-Single		
E/E + Family				Out-of-Pocket-Family		
				Prescription Copay		

Current Carrier Dual Option		Effective Date	Renewal Date	Plan Name/Type	Benefits	
					In Network	Out-of-Network
Census	# Enrolled	Beginning Rates	Renewal Rates	PCP Copay		
E/E Only				Specialist Copay		
				Hospital Copay		
E/E + Spouse/ Partner				Deductible-Single		
				Deductible-Family		
E/E + Child or Children				Coinsurance %		
				Out-of-Pocket-Single		
E/E + Family				Out-of-Pocket-Family		
				Prescription Copay		

Included		Items Required for <u>ALL</u> Proposal Requests	Included		Items Required for Experience Based Proposal Requests
Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	(1,2) Confidential Group Risk Questionnaire Signed by Authorized Company Official	<input type="checkbox"/>	<input type="checkbox"/>	Renewal Information for 2 Policy Years Including:
<input type="checkbox"/>	<input type="checkbox"/>	Employee Census ( <i>Excel or Tic Sheet</i> ) Including:	<input type="checkbox"/>	<input type="checkbox"/>	• Claims History ( <i>Minimum 2 12-Month Periods</i> )
<input type="checkbox"/>	<input type="checkbox"/>	• Employee Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>	• Benefit Plan Design for each Period
<input type="checkbox"/>	<input type="checkbox"/>	• Employee Gender	<input type="checkbox"/>	<input type="checkbox"/>	• Separated by Month
<input type="checkbox"/>	<input type="checkbox"/>	• Employee Residence Zip Codes	<input type="checkbox"/>	<input type="checkbox"/>	• Number of Members Coinciding with Claims History
<input type="checkbox"/>	<input type="checkbox"/>	• Out of Area Zip Codes for PHCS quotes ( <i>not to exceed 25%</i> ) <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	Large Claim Report for Each Period Including: ( <i>Required for both Insured &amp; Self-Funded</i> )
<input type="checkbox"/>	<input type="checkbox"/>	• Out of Area COBRA Zip Codes ( <i>not to exceed 15%</i> ) <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	• Dollar Amounts by Claimant
<input type="checkbox"/>	<input type="checkbox"/>	Does the Group Currently Have Retiree Coverage?	<input type="checkbox"/>	<input type="checkbox"/>	• Diagnosis with Resolved vs. Ongoing Assessment
<b>Additional Items Required for Self-Funded Groups</b>			<input type="checkbox"/>	<input type="checkbox"/>	Specific Stop Loss Limit:
			<input type="checkbox"/>	<input type="checkbox"/>	• Renewal: _____
			<input type="checkbox"/>	<input type="checkbox"/>	• Period A _____ ( <i>Most Current 12-Month Period</i> )
			<input type="checkbox"/>	<input type="checkbox"/>	• Period B _____ ( <i>Prior 12 Months</i> )
<b>Self-Funded Rate Components</b>			<input type="checkbox"/>	<input type="checkbox"/>	Specific Stop Loss Report for Each Claim Period ( <i>Dollar Amounts Paid Over SSL</i> )
			<input type="checkbox"/>	<input type="checkbox"/>	Aggregate Stop Loss Report for Each Claim Period
			<input type="checkbox"/>	<input type="checkbox"/>	Aggregate Stop Loss Cost:
			<input type="checkbox"/>	<input type="checkbox"/>	• E/E Only _____
	<input type="checkbox"/>	<input type="checkbox"/>	• E/E + Spouse _____		
	<input type="checkbox"/>	<input type="checkbox"/>	• E/E + Children _____		
	<input type="checkbox"/>	<input type="checkbox"/>	• E/E & Family _____		
	<input type="checkbox"/>	<input type="checkbox"/>	Admin Fees ( <i>per E/E</i> ) _____		
	<input type="checkbox"/>	<input type="checkbox"/>	Network Fees ( <i>per E/E</i> ) _____		
	<input type="checkbox"/>	<input type="checkbox"/>	Reinsurance Fees ( <i>per E/E</i> ) _____		

(1) Required on all groups with less than 100 eligible employees regardless of funding method.

(2) All YES answers on the Confidential Group Risk Questionnaire MUST have explanations provided.

### Comments

Single Option Plans Requested:	Rx:
Dual Option Plans Requested:	Rx:
RMHP Representative:	Date:

## Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or [eeoofficer@rmhp.org](mailto:eeoofficer@rmhp.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

# Multi-Language Insert



<b>English</b>	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
<b>Spanish</b>	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).
<b>Vietnamese</b>	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-346-4643 (TTY: 711).
<b>Chinese</b>	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-346-4643 (TTY: 711)。
<b>Korean</b>	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
<b>Russian</b>	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
<b>Amharic</b>	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711)።
<b>Arabic</b>	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-346-4643 (رقم هاتف الصم والبكم: 711).
<b>German</b>	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
<b>French</b>	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
<b>Nepali</b>	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
<b>Tagalog</b>	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-346-4643 (TTY: 711).
<b>Japanese</b>	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-346-4643 (TTY:711) まで、お電話にてご連絡ください。
<b>Cushite/Oromo</b>	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-346-4643 (TTY: 711).
<b>Persian</b>	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-346-4643 (TTY: 711) تماس بگیرید.
<b>Ibo/Igbo</b>	Ige nti: O buru na asu lbo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
<b>Kru-Bassa</b>	Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̩ [Bàsɔ̀ò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò b̩éin m̩ gbo kpáa. Đá 1-800-346-4643 (TTY: 711)
<b>Yoruba</b>	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).