P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-5038/800-538-5038
selecthealth.org

selecthealth

Large Group Data Summary Medical

Date Submitted _____ Date Needed _____ Effective Date Requesting _____

Current Contract Renewal Date _____ Sales Rep. _____ Ph# (_____)_____

Company Name_____ Broker _____ Ph# (_____)_____

Federal Tax ID Number (EIN)_____ Street Address _____

City _____ State _____ ZIP _____

ATTACHMENT CHECKLIST

Groups with less than 100 enrollees must provide all of the following:

- ❑ Group Health Risk Evaluation
- ❑ Current Plan Summary of Benefits
- ❑ Prior Month's Insurance Billing
- ❑ *Current Census (enrolled + not enrolled specified)
- ❑ Rate History (past two years)
- ❑ Experience Reports (if available)

Groups with more than 100 enrollees must provide all of the following:

- ❑ Group Health Risk Evaluation
- ❑ Current Plan Summary of Benefits
- ❑ Prior Month's Insurance Billing
- ❑ *Current Census (enrolled + not enrolled specified)
- ❑ Experience Reports (past two years)

*Census **must** include age or date of birth, gender, and tier

SUMMARY OF EMPLOYEES

	In Area	Out-of-Area	Total		In Area	Out-of-Area	Total
Eligible Employees	_____	_____	0	Have Signed Waivers of Coverage	_____	_____	0
Currently Covered on Plan	_____	_____	0	In New-Hire Waiting Period	_____	_____	0

ELIGIBILITY GUIDELINES

Minimum Hours Per Week _____ New Employees are covered on _____ of month following _____ days/months of employment

Employee's Coverage Terminates on ❑ Date of Termination ❑ End of Month

Are retirees covered? ❑ Yes ❑ No If yes, please attach retiree policy.

Does this group have a rehire policy? ❑ Yes ❑ No If yes, please attach rehire policy.

Does this group have a leave policy? ❑ Yes ❑ No If yes, please attach leave policy.

Waiting periods for dental benefits, if applicable _____

SelectHealth allows 60 days for non-FMLA leave and does not include any provisions for rehires.

COMPANY INFORMATION

Current Funding Method: ❑ Fully Insured ❑ Partially Insured ❑ Self Funded**

Requested Funding Method: ❑ Fully Insured ❑ Partially Insured ❑ Self Funded (Group must have 200 or more enrollees)

Current Carrier/Administrator ❑ 5+yr ❑ 4yr ❑ 3yr ❑ 2yr ❑ 1yr _____

Prior Carrier/Administrator ❑ 5+yr ❑ 4yr ❑ 3yr ❑ 2yr ❑ 1yr _____

Description of Industry or Service Provided (SIC Code) _____

Current Medical Rates:

Employee $_____ Employee + Spouse $_____ Employee + Child(ren) $_____ Employee + Child $_____ Family $_____

Employer Contributions:

Employee %_____ Employee + Spouse %_____ Employee + Child(ren) %_____ Employee + Child %_____ Family %_____

Proposed Renewal Increase %_____ Match Current Benefits? ❑ Yes ❑ No

**Groups that are currently self funded must provide:

❑ Group Health Risk Evaluation ❑ Current Census ❑ Funding Data Sheet Form

❑ 24 Most Recent Months of Experience ❑ Current Plan Summary of Benefits

Comments _____