BlueCross BlueShield of Texas

Mid-Market Request for Proposal

Please complete this entire RFP (2 pages) and submit it to: TexasRFP51100@bcbstx.com

NOTE: *Group must be headquartered in Texas to qualify for an Underwritten Quote.*

Legal Group Name

EIN (9-digits) SIC (4-digits) Requested Effective Date

Employer Physical Address

City State Zip Code County

List current and prior carriers, if applicable. Include coverage dates and years: MM/DD/YYYY - MM/DD/YYYY

Current Carrier

Prior Carrier

Producer Information: *Producer and General Agent sections must be completed in full.*

PCPM Medical commission amount ($35 is default)

Primary Producer Name

BCBSTX Assigned Producer Number (9 digits) Current agent? (Y/N)

Sub Producer/Writing Agent Name

BCBSTX Assigned Sub Producer/Writing Agent Number (9-digits)

Sub Producer/Writing Agent Producer Location (City and State)

General Agent Information: *Leave blank if not applicable.*

General Agent Name

BCBSTX Assigned General Agent Number (9-digits)

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Eligibility

	Total on Payroll
	(Plus) COBRA
	(Plus) Retirees
	(Minus) Part-time
	(Minus) Employees in waiting period
	(Minus) Waiving due to other coverage
	(Minus) Waiving due to cost
0	= Total Enrolled

Employer Contribution ($ or %)

Waive the Initial Waiting Period (Y/N)

Length of Waiting Period (0, 30, 60)

Please submit the following with this form:

Current Rates

Renewal Rates

Current Summary of Benefits (SBC)

Full member-level census is required excel template (instructions listed in template):

Required Census Information

- All eligible enrolling Employees and their Dependents.
- List Employee on the first row and include Last Name, First Name, Relationship Code (Employee), DOB, Gender, Coverage Type, and Zip Code (home).
- List Dependents under Employee, Spouse first then Dependents. Include Last Name, FirstName, Relationship Code (Spouse or Dependent), DOB, Gender, and Zip Code (home).
- Employees must include Coverage Type (EO, ES, EC, or EF).
- Include COBRA and/or retirees, if applicable. Use Coverage Type for COBRA as CO, CS, CC, or CF.

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