BlueCross BlueShield of Illinois

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

Request for BluePrint Intermediate Proposal

Please submit this form, completed in its entirety, along with the *group's complete renewal package (text, rates, benefits, and reports)*. This information is required in order to complete an Intermediate Proposal request.

Please note that Intermediate Proposal rates are not final rates. Final rates are still subject to a full case submission and underwriting review.

Sales Exec_____ Broker/Agency_____
Effective Date __/_____/_____ Initial Proposal Opportunity # (lower left corner of cover page) _____
Employer Name_____ Employer Tax ID # _____
Type of Business_____ SIC Code_____ Original Business Start-up Date_____/_____/_____
Phone #_____ D & B # _____

Prior Group Coverage with BCBSIL?_____Yes_____No. If Yes, provide Cancellation Date_____/_____/_____ Group Number _____
Is the Group's current funding arrangement fully insured?_____Yes_____No
What is the Group's current health coverage renewal date? __/_____/_____

Insurance Company History (All Insurance Companies, including HMO, in the previous five years)
Current: _____ Period Insured _____
Previous _____ Period Insured _____
Previous _____ Period Insured _____
Previous _____ Period Insured _____

Total number employees currently enrolled_____

Total number of retirees currently enrolled_____(No more than 15% of enrollees can be retirees.)
Total number of COBRA enrollees_____(No more than 15% of the employees can be on COBRA.)
Total number of 1099 employees enrolled_____(No more than 10% of the employees can be 1099.)

Medical Questions: Please answer Yes or No to the following questions.

1. Has anyone had a claim of $5,000 or more in the last 12 months?_____
2. Has anyone been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? _____
3. Has anyone been advised, diagnosed or treated by a physician in the past 5 years for:
   - A. Stroke, Cardiovascular Disease or Heart Attack, Heart Disease or Disorder, Arteries, Blood, Blood Vessels?_____
   - B. Cancer or Cancerous Tumor?_____
   - C. Asthma, Tuberculosis, Emphysema, Lungs or Respiratory System Disorder?_____
   - D. Diabetes Non-Insulin Dependent, Diabetes Insulin Pump, Diabetes Insulin Dependent?_____
   - E. Hepatitis, Liver Disorder?_____
   - F. Growth Disorder, Pancreas Disorder?_____
   - G. Chronic Kidney Stones, Prostate Disorder, Kidney Disorder or Bladder Disorder?_____
   - H. Mental/Emotional Disorder?_____
   - I. Seizures/Epilepsy, Brain Disorder, Paralysis, Nervous System Disorder?_____
   - J. HIV Positive, Lupus, AIDS, Immune System Disorder, Diseases Associated with AIDS?_____
   - K. Alcohol/Drug/Substance Abuse or Dependency?_____
   - L. Organ Transplant, Bone Marrow Transplant?_____
4. Is any Employee, Spouse or Child pregnant or has anyone been treated for infertility, taken any medication for infertility or been advised to seek treatment, medication, diagnostic tests or surgery for infertility?_____

Give details of all "Yes" answers to the above questions in the spaces provided below. Additional information may be required.

Question # (1-4)	Age	Medical Diagnosis	Date(s) of Treatment	Date of Recovery	Names of Medications	Total Amount ($) Of Claims (for reasons specified)

Participation must equal at least 70% of those eligible employees who are not waiving Blue Cross coverage due to other Spousal or Parent GHP coverage, Government programs including Medicare and Medicaid, Individual policies, and COBRA or Retiree benefits from a prior employer. In no event can participation be lower than 35% of all eligible employees.

Internal Use Only
UW _____
GS _____