BlueCross® BlueShield® of South Carolina

Agency Sales Department
Mail Route BR-105
www.SouthCarolinaBlues.com

1000 Executive Center Drive, Greenville, SC 29615 (864) 288-5791 or 1-800-922-1185 (864) 676-0122 FAX

2 - 50 PROPOSAL REQUEST FORM

Agent's Phone Number		Group Name: _	Agent's FAX	0) □ Sherri Agent's BCBS Number: (Number:						
County in which group SIC Code: Workers' Compensatio # of Employees:	is located: _ Do n:	escription of bus No bu have any emp multi-location?	siness: oloyees out-of-state?	' □ Yes □ No						
All Contracts will be issued as: Calendar Year Deductible Benefit Period Deductible Dual Option: Yes No If yes, choose your Dual Option combination: Dual Options may consist of the following combinations: Business Blue SM Complete (Preferred Blue®) Plan with HDHP Business Blue SM Secure Plan with HDHP Dual options are only available to groups with seven or more employees enrolled and may not include a Business Blue Complete (Preferred Blue) Plan with 90/70 coinsurance or with deductibles of \$250 or \$500.										
□ Business Blue Complete (Preferred Blue)	Coinsurance: (pick one) 90/70 80/60 70/50 60/40	(pick one) ☐ \$250 ☐ \$500 ☐ \$1,000	Out-of-Pocket: (In/Out) (pick one) \$1,500/3,000 \$2,000/4,000 \$3,000/6,000 \$5,000/10,000	Options for Business Blue Complete \$20/\$40 Office Visit Copayment \$35 /\$60 Office Visit Copayment Chiropractic Dental Standard Option Orthodontics (13-50 enrolled) 2-6 size groups = 100% of those enterprollment status must be the same	t					
□ Business Blue Secure	Coinsurance: (pick one)	Deductible: (In/Out) (pick one) □ \$1,250/2,500 □ \$1,750/3,500 □ \$2,250/4,500 □ \$3,250/6,500 □ \$4,250/8,500 □ \$5,250/10,500	Out-of-Pocket: (In/Out) (pick one) \$1,750/3,500 \$2,250/4,500 \$3,750/7,500 \$5,250/10,500		ne for health and dental.					

☐ Business Blue ^{SN}	[↑] High Deducti										
(HSA Qualified I	HDHP)		HD1	☐ HD2		☐ HD3		☐ HD4		☐ HD5	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	I	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$2,600	\$2,600	\$2,600	\$2,600
Deductible – family		\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$5,200	\$5,200	\$5,200	\$5,200
Coinsurance		100%	60%	80%	60%	70%	50%	100%	60%	80%	60%
Out-of-Pocket – sin	•	\$1,500	\$3,000	\$3,000	\$4,500	\$3,000	\$4,500	\$2,600	\$5,200	\$5,200	\$7,800
Out-of-Pocket – far	nily _	\$3,000	\$6,000	\$6,000	\$9,000	\$6,000	\$9,000	\$5,200	\$10,400	\$10,400	\$15,600
			HD6		□ HD7 □ HD8		HD8	☐ HD9		☐ HD10	
		IN	N OUT IN		OUT	IN OUT		IN OUT		IN OUT	
Deductible – single		\$2,600	\$2,600	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$5,000	\$5,000
Deductible – family		\$5,200	\$5,200	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$10,000	\$10,000
Coinsurance		70%	50%	100%	60%	80%	60%	70%	50%	100%	60%
Out-of-Pocket - sin	igle	\$5,200	\$7,800	\$3,500	\$5,500	\$5,500	\$7,500	\$5,500	\$7,500	\$5,000	\$10,000
Out-of-Pocket – far	nily	\$10,400	\$15,600	\$7,000	\$11,000	\$11,000	\$15,000	\$11,000	\$15,000	\$10,000	\$20,000
Options for High Deductible Health Plans: ☐ Chiropractic ☐ Dental High Option 2-6 size groups = 100% of those enrolled in health must enroll in dental. ☐ Dental Standard Option ☐ Orthodontics (13-50 Enrolled) Enrollment status must be the same for health and dental. ☐ We will open HSA accounts through BlueCross BlueShield of South Carolina.											
☐ Life Insurance and AD&D: Amount: Dependent Life Coverage: ☐ Yes ☐ No *2-12 Employees – increments of \$10,000 up to \$50,000											
☐ Short Term Disability: ☐ 13 weeks ☐ 26 weeks % of Earnings:% Flat Weekly Benefit: Max Weekly Benefit:											
 □ Long Term Disability: % of Earnings:% Elimination Period: □ 90 days □ 180 days Maximum Weekly Benefits:*Job title and salary information of each employee is needed. 											
Plan Requests – Fill in what plans you want to be run by the proposal coordinator (Marketing Assistant).											
Plan Requests	Selection I	A	Selection	В	Selection C		Selection D		Selection E	Se	lection F
Plan Type											
Deductible											

Plan Requests	Selection A	Selection B	Selection C	Selection D	Selection E	Selection F
Plan Type						
Deductible						
Coinsurance						
Out-of-pocket						
Rx Card						

PROPOSAL CENSUS FORM									
EMPLOYEE NAME	DOB MM / YY	SEX	COVERAGE TYPE (see explanation below)		SPOUSE'S DOB MM / YY	LIFE AMT.	ANNUAL SALARY (if applicable)		
1.	,	M F	S	F	EC	ES	1		,,
2.	,	M F	S	F	EC	ES	,		
3.	/	M F	S	F	EC	ES	/		
4.	/	M F	S	F	EC	ES	/		
5.	,	M F	S	F	EC	ES	/		
6.	/	M F	S	F	EC	ES	1		
7.	/	M F	S	F	EC	ES	1		
8.	/	M F	S	F	EC	ES	1		
9.	/	M F	S	F	EC	ES	/		
10.	/	M F	S	F	EC	ES	/		
11.	/	M F	S	F	EC	ES	/		
12.	/	M F	S	F	EC	ES	/		
13.	/	M F	S	F	EC	ES	/		
14.	/	M F	S	F	EC	ES	/		
15.	/	M F	S	F	EC	ES	/		
16.	/	M F	S	F	EC	ES	/		
17.	/	M F	S	F	EC	ES	1		
18.	/	M F	S	F	EC	ES	1		
19.	/	M F	S	F	EC	ES	1		
20.	/	M F	S	F	EC	ES	1		
21.	/	M F	S	F	EC	ES	1		
22.	/	M F	S	F	EC	ES	1		
23.	/	M F	S	F	EC	ES	1		
24.	/	M F	S	F	EC	ES	1		
25.	/	M F	S	F	EC	ES	/		
26.	/	M F	S	F	EC	ES	/		
27.	/	M F	S	F	EC	ES	/		
28.	/	M F	S	F	EC	ES	1		
29.	/	M F	S	F	EC	ES	/		
30.	/	M F	S	F	EC	ES	/		
31.	/	M F	S	F	EC	ES	/		
32.	/	M F	S	F	EC	ES	/		

COVERAGE TYPE: S = Single Coverage

Family Coverage F

= Employee and Child(ren) Coverage EC

Employee and Spouse Coverage ES =

DOB = Date of Birth

(Must be month and year, for example: 02/48 – can no longer accept age.)