UPMC HEALTH PLAN

Rate Request Form
For employer groups with 51+ employees
(10+ enrolled for Self Assure Level Funding)

1. Producer information

Agency name: Contact name:

Phone number: Email: Date submitted:

Are you the current producer of record for medical and pharmacy? ☐ Yes ☐ No

If no, state your relationship to the group:

Commission requested (if 100+):

2. Employer group information

Employer group name:

Address:

City: State: ZIP code: County:

Contact name: Email:

Phone: Fax:

Avg. EE Count: No. of eligible EEs: No. of OOA EEs: SIC code: Industry:

Current carrier: Current funding arrangement: ☐ Fully Insured ☐ Self Funded ☐ Level Funded

Years with current carrier: Renewal date: Requested effective date:

Are you including benefit grids? ☐ Yes ☐ No Does the employer fund an HRA? ☐ Yes ☐ No

If yes, how much funding and when (%/first/last)?

Does the employer have workers' compensation? ☐ Yes ☐ No If yes, carrier name: _____

Does the employer offer dental insurance? ☐ Yes ☐ No If yes, carrier name: _____ ☐ Voluntary ☐ Contributory

Does the employer offer vision coverage? ☐ Yes ☐ No If yes, carrier name: _____ ☐ Voluntary ☐ Contributory

Has the employer been in business for at least three months? ☐ Yes ☐ No

Does the employer have union employees? ☐ Yes, name of union: ☐ No

Does the employer purchase benefits through an association? ☐ Yes, name: ☐ No

Is the employer a former UPMC Health Plan client? ☐ Yes, list when: ☐ No

Reason employer is out for bid: ☐ Cost ☐ Network ☐ Benefit designs ☐ Customer service ☐ Health care management

Requested funding arrangement: ☐ Fully insured ☐ ASO fee ☐ Self Assure Level Funding ☐ ASO & Stop Loss

3. Medical premium/claims information

For groups with more than 100 eligible employees, provide monthly experience data for 12 to 36 months. Include separate medical/pharmacy claims, monthly enrollment, and large claims over $25,000 by experience period with diagnosis and prognosis.

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution ($ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

4. Dental premium/claims information

For groups with more than 100 eligible employees, provide monthly experience data for 12 to 36 months.

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution ($ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

5. Vision premium/claims information

	Previous Rates	Current Rates	Renewal Rates	Employer Contribution ($ or %)	
				Employee	Dependents
Employee Only					
EE & Spouse					
EE & Child					
EE & Children					
EE & Family					

6. Census information

Attach a complete census that include the name, date of birth, gender, coverage tier, ZIP code, and current plan option (if multiple plans are offered) of each eligible employee. All eligible employees must be included, even if they are waiving coverage. Clearly identify out-of-area employees.

7. Product information

Indicate specific UPMC Health Plan products that are being requested.

Rx plan:	**PPO:**	**EPO:**	**UPMC *HealthyU*:**
HRA:	**HSA:**	**HMO:**	**UPMC MyCare *Advantage*:**
UPMC Inside *Advantage*:	**Out-of-Area:**	**Dental:**	**Vision:**
Other:			

UPMC Health Plan

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