



ODS Alaska Proposal Request Form (51-99 groups)

Proposed Effective Date: _____
 Business Name: _____
 Address: _____
 City/State/ZIP: _____
 Contact: _____
 Title: _____
 NAICS Code: _____
 Reason for Quote: _____
 Monthly employer employee contribution: _____
 Current medical insurance carrier: _____

REQUESTED TYPE OF PLAN:
 Standard PPO HSA Beneficial PPO
 Agent: _____
 Current Client Prospective Client

Phone Number: (____) _____
 Fax Number: (____) _____
 E-mail: _____
 Monthly dependent contribution: _____
 Number of employees outside of Alaska: _____

BENEFITS

MEDICAL

CURRENT REQUESTED

Deductible		
Office Visit		
Coinsurance		
Out of pocket		
Rx Benefit Plan		
Alt. Care		
Vision		

DENTAL

CURRENT REQUESTED

Deductible		
Coinsurance		
Annual Max.		

RATES

CURRENT (Med/Vis/Rx)			
EE	EE/SP	FAM	EE/CH
RENEWAL (Med/Vis/Rx)			
EE	EE/SP	FAM	EE/CH

CURRENT (Dental)			
EE	EE/SP	FAM	EE/CH
RENEWAL (Dental)			
EE	EE/SP	FAM	EE/CH

Comments: _____

Large Claim Disclosure Form

Please provide the information below to assist us in properly underwriting and rating your group. For purposes of this disclosure, a "Large Claim" is an injury or illness (whether acute or chronic) whose total costs of treatment (including both insured costs and costs paid by the patient) exceed \$10,000 over any 12 month period.

1. Please describe any Large Claims your group (including covered employees and covered dependents) has experienced in the past 24 months. Please provide approximate dates, the nature of the illness or injury and the resolution. **Do not provide any information identifying the individual involved (name, member number, address, etc.)**

2. Please describe any Large Claims that involve ongoing treatment that can reasonably be expected to continue into the next plan year.

3. Please give the number of employees who are:

- a.) Currently pregnant or have HIV
- b.) Anticipating surgery or hospitalization within the next three months
- c.) Currently confined to a hospital or other treatment facility
- d.) Currently disabled

Certification

This above information is accurate and complete, to the best of my knowledge. I understand that ODS Health Plan, Inc. will rely on this information to provide a tentative quote. I acknowledge that inaccurate or incomplete information may result in an inaccurate quote.

Name: _____ Title: _____
 Signature: _____ Date: _____