MINNESOTA STATE BAR ASSOCIATION
EMPLOYER QUESTIONNAIRE

BlueCross BlueShield Minnesota

Company name: _____

Company address: _____

City, State, ZIP: _____

Primary SIC Code: _____

Tax identification number: _____

Decision maker's name: _____

Direct phone number: _____

Email address: _____

Total number of eligible full-time employees: _____ Are retirees or early retirees eligible? * ☐ YES ☐ NO

Are Union employees eligible? ☐ YES ☐ NO

*For Minnesota State Bar Association quotes, retirees and 1099 contractors are excluded.

Total number of full-time employees working 20 or more hours per week in the previous calendar year, including all employees that are part of a controlled group (as defined in Section 414 of the Internal Revenue Code): _____

Is your company a controlled group or part of a controlled group? ☐ YES ☐ NO

If you are part of a controlled group, complete the controlled group form X18207.

Approximate number of employees requesting coverage: _____

Approximate number of employees out of state, by state: _____

Employer monthly medical premium contribution: Single: $ _____ Family: $ _____

Or Single: _____% Family: _____%

Employer sponsored: ☐ HRA ☐ HSA ☐ Stackable HRA/HSA ☐ VEBA

Annual Single contributions: $ _____ Annual Family contributions: $ _____

Does your company have an Individual Coverage Health Reimbursement Arrangement (ICHRA)? ☐ YES ☐ NO

If YES, provide the class(es) of employees who are eligible for the ICHRA: _____

1. Are any employees or dependents currently covered by your group health plan currently disabled or hospitalized?
   ☐ YES ☐ NO ☐ UNKNOWN

If yes, provide the following information:

Reason for disability or hospitalization	Begin date	End date	Estimated cost

2. Have any members covered by your health plan had claims over $50,000 in the past two years?
☐ YES ☐ NO ☐ UNKNOWN

If yes, provide the following information:

Reason for high claim	Begin date	End date	Estimated cost

3. Are you aware of any of the following health conditions of any member of your health plan, now or in the past 12 months?
   a. **Identified as a candidate for Cell Therapy or Gene Therapy**: ☐ YES ☐ NO
   b. Awaiting or has received an organ and/or tissue transplant: ☐ YES ☐ NO
   c. Newborn with major health problems, respirator dependent and/or extremely low birth weight: ☐ YES ☐ NO
   d. Cancer in the last two years: ☐ YES ☐ NO
   e. Other serious health problems: ☐ YES ☐ NO
   f. If yes to any of the above, or if you are aware of any emerging conditions of a catastrophic nature that are not reflected in the claims experience provided, provide known details:

_____

_____

_____

4. How many employees and/or dependents are on COBRA: _____
   a. Do they have known health problems? ☐ YES ☐ NO ☐ UNKNOWN

5. Current carrier information:
   a. Current Medical carrier: _____# Years with carrier _____
      Attach most recent renewal letter and any attachments.
      Current Agent Commissions: _____% of premium or $_____ per contract per month or $_____ per month
   b. Current Dental carrier: _____# Years with carrier _____
   c. Current Vision carrier: _____# Years with carrier _____

6. Miscellaneous information:
   a. Is your company part of a Multiple Employer Welfare Arrangement (MEWA)? ☐ YES ☐ NO
   b. Is your company part of a Professional Employee Organization (PEO)? ☐ YES ☐ NO
      If any of the above are yes, provide additional information.
   c. Is your company currently a member of the Minnesota State Bar Association? ☐ YES ☐ NO*
      *If NO, please note that membership in the Minnesota State Bar Association is required.

Employer certification:

As a representative of the named employer, I certify that the information provided is complete and accurate to the best of my knowledge available to the employer. The employer has completed appropriate due diligence in obtaining the requested information and I am in a position to certify this on behalf of the employer.

I further understand that the information provided here will be relied upon by Blue Cross and Blue Shield of Minnesota and if such information is materially incomplete or incorrect, the coverage will be subject to the rate adjustment, with 30 days' notice.

Name: (printed): _____

Title: _____ **Date:** _____

The purpose of this questionnaire is to obtain information on potential claims and utilization. This information along with requested documentation will be used to determine the appropriate rate level. Your assistance is appreciated.

Blue Cross and Blue Shield of Minnesota Underwriting Requirements

For Medical (all large groups), Dental (employers with 100 or more enrolled employees), and Vision (employers with 1,000 or more eligible employees)

1. Claims Experience: 24 months of documented experience from the current carrier consisting of premium received, claims paid, administration fees (ASO) paid. Claims must be broken out by plan if there are multiple plans in place. Utilization must be current and consecutive. For Vision only, claim counts broken out by exam and type of lens are preferred.
2. Premium rates that coincide with the claims utilization. This should also include the proposed rates from the incumbent carrier.
3. Benefit outline that coincides with the claims utilization, including non-network reimbursement level for Dental only.
4. Enrollment: the number of singles/families and/or members covered by month during the claims utilization period.
5. Employee census: including employee identifier, date of birth, gender, employee home zip code, plan option elected if multiple plan offerings, tier elections (e.g. single/family), and employee status (i.e. salaried/hourly, union/non-union) if applicable.
6. Employer contribution toward single and family premiums.
7. Employer address, nature of business and current membership status in the Minnesota State Bar Association.