Small Group Benefit Modification Inquiry

All HMO Medical plans, Premier $10/$20 Copay plans and PPO $30/$40 Copay plans are offered by BCC.
All other Medical, Term Life and AD&D products are offered by BCL&H.

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This form may be used for preliminary review of existing groups (with medical coverage already) requesting to upgrade to the EmployeeElect Plus program. This form is not to be used for Risk Adjustment Factor (RAF) reviews, benefit downgrades or adding medical coverage to existing dental/life groups.

	Underwriting Unit: UW3	**FAX No:** 805-713-7024
Supervisor	Roxann Breazile	

Group Information

(1099 employees are not eligible for coverage)

Group Name		Group No.	Date Inquiry Submitted
No. of Full-time Employees	No. of Part-time Employees	No. of Pregnancies in Group Due dates: / / / / / /	
Agent Name	Agent ID No. _	Phone No. ( )	FAX No. ( )
General Agent Name	General Agent ID No. _	Phone No. ( )	FAX No. ( )

Plan Choice

☐ All plans OR ☐ Designate specific plan options *(Check as many as apply)*

☐ Basic PPO	☐ Advantage PPO $25 Copay	☐ Power HealthFund 750	☐ Classic HMO
☐ Saver PPO	☐ Premier PPO $20 Copay	☐ Power HealthFund 500	☐ HMO 100%
☐ PPO $35 Copay w/GenRx	☐ Premier PPO $10 Copay	☐ High Deductible EPO	☐ Other _____
☐ PPO $40 Copay	☐ PPO 3500 (HSA-Compatible)	☐ Power Select HMO	
☐ PPO $30 Copay	☐ PPO 2400 (HSA-Compatible)	☐ Saver HMO	☐ BC Life Insurance

Medical Conditions

To your knowledge, has any employee or dependent had claims resulting in expenses in excess of $2,500 in the last six (6) months? ☐ Yes ☐ No
If yes, please complete the information below. Attach additional pages as needed.

Employee/Dependent Data

Specific Diagnosis	Date of Onset	Medication(s)	Prognosis / Current Treatment
			Prognosis
			Current Treatment
			Prognosis
			Current Treatment
			Prognosis
			Current Treatment

General Conditions and Questions

Underwriting Response – *All documentation must be received 30 days prior to the requested effective date.*

Potential for:
☐ Approval ☐ Decline
OR:
☐ Need additional information *(See notes below)*

Submit with:
☐ New employer application ☐ Change of Coverage – Application for those employees requesting to change *(Medical only)*
☐ Letter from group requesting change ☐ DE6

Notes

Name of Underwriter	Unit No.	Phone No. ( )	Date

Preliminary decisions resulting from this inquiry are based solely upon the completeness and accuracy of the information provided. If you apply for this benefit modification, please be sure to include a copy of this inquiry and our response with any additional documentation that we may ask for. This response does not guarantee that the benefit modification will be approved. The final decision will be based upon the underwriter's review of all documentation submitted.

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