BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

☐ Medical Only Quote

☐ Medical and Dental Quote

BlueFreedom

Request for Pre-Screen

Current and renewal rates and plan design for medical and dental, if applicable, are required, when available, at the time of submittal.

Provide **medical** information below:

Group Name: _____

City and Zip Code: _____

Industry Description: _____

NAICS Code: _____

Effective Date: _____

Total Eligible Employees: _____ Number of Enrolled Employees: _____

Total Employees (average in prior calendar year): _____

Number of Waivers with Other Coverage: _____

Number of Waivers without Other Coverage: _____

Employer Contribution: Employee: _____ Employee & Spouse: _____

Family: _____ Employee & Child(ren): _____

Number of COBRA Enrollees: _____

Number of Enrolled Employees Residing Outside Nebraska: _____

Current/Prior Carrier: _____

Current Funding Type (FI, ASO, Level Funded, etc): _____

Submitted By: _____
Broker Name

_____
Agency Name

_____
Email Address

Return by Sales Rep or Mail to:
Email: Blue_Freedom@nebraskablue.com
Blue Cross and Blue Shield of Nebraska
Attention: Underwriting Services
1919 Aksarben Drive
PO Box 3248
Omaha, NE 68180-0001

NOTE: Prior Carrier Bill for medical and dental, if applicable, is required with the submittal of the completed Master Group Application.

Proof of prior coverage will be required to receive discounted dental rates.