

STOP LOSS REQUEST FOR PROPOSAL (RFP)

Rep/Underwriter: _____ UW Assistant: _____
 Date Submitted: _____ Due Date: _____ Effective Date: _____
 Address: _____ State: _____ Zip Code: _____
 Industry Description: _____ SIC Code: _____
 Commission Current: _____ Commission Requested: _____

If Fully Insured, Current Carrier(s): _____
 Rates & Enrollments Attached: Current Renewal
**Include Enrollment for Each Fully Insured Rate Tier*

Current Self Funded Carrier: _____
 Broker: _____
 Current TPA(s): _____ Proposed TPA(s): _____
 Current PPO(s): _____ Proposed PPO(s): _____

Type of Retiree Coverage: All Under Age 65 Not Applicable

Current Specific Coverage	Requested Specific Coverage
Current Specific Deductible: _____	Requested Specific Deductible: _____
Current Specific Corridor: _____	Requested Specific Corridor: _____
Current Specific Contract: _____	Requested Specific Contract: _____
Current Specific Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Rx Card	Requested Specific Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Rx Card
Annual Spec. Maximum: _____	Requested Annual Spec. Maximum: _____
Lifetime Spec. Maximum: _____	Requested Lifetime Spec. Maximum: _____
Lasers: _____	Lasers: _____
No New Laser with Rate Cap: <input type="checkbox"/> Yes <input type="checkbox"/> No	NNL with Rate Cap Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, maximum rate increase (%): _____	<i>*May not be offered on all prospects</i>
If Yes, Please identify any current lasered individuals and amounts on their lasers: _____	_____
_____	_____
_____	_____
If Hospital Group, Domestic Claims Reimbursement Percentage (%): _____ Current _____ Requested	

Current Aggregate Coverage	Requested Aggregate Coverage
Current Aggregate Contract Basis: _____	Requested Aggregate Contract Basis: _____ <i>(List Options if Applicable)</i>
Current Aggregate Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Rx Card <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Requested Aggregate Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Rx Card <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Current Aggregate Maximum: _____	Current Aggregate Maximum: _____

The following information must be included to provide a quote:
<p>Current year 50% report showing DX, PX and paid amounts, trigger report, pre-cert report, LCM notes, pending and denied report</p> <p>2 prior plan years of large claims provided</p> <p>If aggregate coverage requested, paid claim experience (for all coverages included). Current & prior 2 full years</p> <p>Experience reports run by effective date</p> <p>Schedule of benefits included</p> <p>Rates/factors provided</p> <p>Census (Must have zip, DOB or age, coverage (S F ES EC), status (active, retiree, cobra), gender, plan type (breakdown)</p> <p>Special Treaty (Overrides to be included HLC, RLJ, BH)</p> <p>E-Census to be saved as: _____</p>

Comments:	
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