



SummitRe
Summit Reinsurance Services, Inc.
www.Summit-Re.com

REQUEST FOR PROPOSAL FOR EMPLOYER STOP LOSS

Return the completed RFP to:

**Summit Reinsurance Services, Inc.
7030 Pointe Inverness Way, Ste. 350
Fort Wayne, IN 46804
Telephone: (260) 469-3000
Fax: (260) 469-3014**

1. EMPLOYER INFORMATION:

Name of Employer: _____

No. of Employees: _____

Address: _____

SIC Code: _____

Years in Business: _____

Effective Date: _____

Date Requested: _____

Date Due: _____

LOCATION(S) OF ALL EMPLOYEES				
Street	City	State	Zip Code	No. of covered EEs

A. Please list all insureds who are currently on COBRA: _____

B. List the name of any employee who is currently disabled: _____

C. Are union members covered under this plan? Yes: ___ No: ___ If yes, how many: ___

D. Are retirees covered under this plan? Yes: ___ No: ___ If yes, how many: ___

E. Has the employer ever filed for bankruptcy? Yes: ___ No: ___

F. What is the employer contribution? EE: ___ DEP: ___ Participation %: _____

2. HMO OR THIRD PARTY ADMINISTRATOR:

Company Name: _____

Address: _____

Contact: _____ Contact Phone: _____

3. PLEASE INCLUDE THE FOLLOWING:

- A. Current Medical Plan Description:
- B. Current Dental Plan Description:
- C. Details of any plan changes over the past 3 years, including amendments if available:
- D. Current census: Date of Birth, Sex & Dependent Coverage*:
- E. Claims Experience for the past three years:
- F. Shock Claims which include Amount Paid, Date(s) Paid, Diagnosis & Prognosis**:

*Can summarize above info. in 5 year increments (0-29, 30-34, 35-39, 40-44, 45-49, etc.....)

**Shock claims are the lesser of \$20,000, or 50% of the proposed specific deductible, or are expected to exceed 50% of the proposed specific deductible during the proposed year.

4. WHAT MANAGED CARE PROGRAMS DO YOU HAVE IN PLACE?:

- A. Precertification: Yes: ____ No: ____
- B. Concurrent Review: Yes: ____ No: ____
- C. Retrospective Review: Yes: ____ No: ____
- D. Medical Case Management: Yes: ____ No: ____
- E. PPO Network: Yes: ____ No: ____
- F. HMO Network: Yes: ____ No: ____

If Yes to any of the above, please provide details:
