



**SummitRe**

Summit Reinsurance Services, Inc.

www.Summit-Re.com

**HMO Proposal Questionnaire**

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID#: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**EXCESS LOSS COVERAGE**

1. For what classification of members are you seeking coverage?

**Member Type:**

- Commercial HMO/PPO/Indemnity
- Medicare Risk
- Medicaid AFDC
- Medicaid SSI
- Child Health / Uninsured
- Other \_\_\_\_\_

**Type of Coverage:**

- Hospital In-Patient Services
- Hospital Out-Patient Services
- Physician Services
- Comprehensive (All) Services
- Other \_\_\_\_\_

2. Excess Loss Coverage Being Requested

- Effective date: \_\_\_\_\_
- Please attach a copy of your current reinsurance agreement. This will give Summit Re a clear understanding of the structure of your current coverage and any non-standard provisions that it might contain.
- Deductible amounts per covered person: List up to 3 options

<u>Category</u>	<u>Deductible Amount</u>	<u>Deductible Amount</u>	<u>Deductible Amount</u>
Commercial:	_____	_____	_____
Medicaid:	_____	_____	_____
Other:	_____	_____	_____

- If physician services are to be covered, please indicate the fee schedule as a percentage of RBRVS, if applicable, and the representative zip code:
- Coinsurance:
- Organ and tissue transplant services are assumed to be covered services unless otherwise specified
  - Transplants excluded?
  - Include coverage for organ donor and acquisition charges
- Average Daily Hospital Maximum – List up to 3 options

\_\_\_\_\_

3. Does your company plan to expand the network during the contract period?  Yes  No  
 If yes, in what area or states do you plan to expand and what is the planned enrollment?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Please attach a summary of your current hospital contracts. This summary should include information on any outlier provisions. Please provide detail in a summarized fashion.

5. Enrollment Information

Please provide monthly enrollment in the following format for the most recent 3 coverage periods;

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Commercial HMO												
Comm. PPO												
Medicare												
Medicaid AFDC												
Medicaid SSI												
Other												

Projected Enrollment for Coming Year

Commercial HMO	
Commercial PPO	
Medicare	
Medicaid AFDC	
Medicaid SSI	
Other	

6. Please attach a copy of your company's latest audited financial statement, as well as the most recent statutory annual and quarterly statements. Please include the most recent actuarial statement of opinion.
7. Please describe the utilization and case management programs and staff qualifications (provide attachments as necessary). Please indicate if specialized programs are in place (e.g. maternity management, disease management).

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8. Please provide catastrophic claims experience (i.e., claims which have exceeded 75% of the lowest reinsurance deductible requested for the last three years. Include diagnosis, name of hospital, and dates of service (or length of stay) for each claimant. Indicate prognosis if claim is ongoing. The following list of data elements are needed per hospital confinement or in total for non-IP type services:

1. Member number
2. Member name
3. Member type (commercial HMO, Medicare, etc.)
4. Provider name
5. Provider type
6. Admission Date
7. Discharge Date
8. Length of Stay
9. Diagnosis Code
10. Diagnosis description
11. Amount billed
12. Amount paid
13. Withholds if applicable

9. Does your plan utilize fee withholds?  Yes  No

If yes, should they be included in the excess reimbursement?  Yes  No

Please attach a description.

10. Please attach a copy of the HMO Evidence of Coverage, if available.
11. Please provide the Plan's the average hospital cost per day and hospital days per 1,000 members for the past three years. Indicate whether mental health and substance abuse days are included.
12. Please attach a listing of claims reimbursed under your reinsurance coverage for the current and past years. Information should include a claim identifier and the amount reimbursed.

I hereby certify that the information provided above is complete and accurate. I understand that in the event Swiss Re issues the insurance coverage being requested, the policy provisions and premium rates will be based on the information provided in this Request for Proposal and any supplementary information. If such information is later found to be incomplete or inaccurate, Swiss Re may, at its discretion, consider that there has been a material change and may adjust premium rates accordingly.

**Completed By:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Please return the completed questionnaire to:**

**Summit Reinsurance Services, Inc.  
7030 Pointe Inverness Way, Ste. 350  
Fort Wayne, IN 46807  
PH 260-469-3000  
FAX 260-469-3014**