



**SummitRe**

Summit Reinsurance Services, Inc.

www.Summit-Re.com

**Medical Excess Proposal  
Questionnaire**

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

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

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

Parent company and subsidiaries \_\_\_\_\_

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

**EXCESS LOSS COVERAGE**

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

<u><i>Insured Type:</i></u>	<u><i>Employee Lives</i></u>	<u><i>Deductible Options</i></u>		
		<u><i>Deductible1</i></u>	<u><i>Deductible2</i></u>	<u><i>Deductible3</i></u>
<input type="checkbox"/> Group PPO	_____	_____	_____	_____
<input type="checkbox"/> Group Indemnity	_____	_____	_____	_____
<input type="checkbox"/> Employer Stop-Loss	_____	_____	_____	_____
<input type="checkbox"/> Individual	_____	_____	_____	_____
<input type="checkbox"/> 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.
- Covered Services
  - Comprehensive (All) Services
  - Other \_\_\_\_\_

- Coinsurance: \_\_\_\_\_
- Organ and tissue transplant services are assumed to be covered services unless otherwise specified

Transplants excluded?

Name of network(s) utilized:

- Underwriting:
  - Copies of policy form(s) to be reinsured.
  - Copy of underwriting guidelines.
  - Description of how state reinsurance pools are used and a listing of any ceded risk.
- Please attach a summary of PPO networks used by geographic locations including information on fee structures. Also to the extent available, please attach a summary of current key hospital contracts. This summary should include information on any outlier provisions and focus on high cost tertiary care centers. Please provide detail in a summarized fashion.
- Enrollment Information  
Please provide annual enrollment in total employee months by insured type category for the most recent three coverage periods.
- Please provide average contract size for group contracts by insured type.
- Please indicate the mix of medical business by the following lifetime maximums.

<u>Lifetime Maximum</u>	<u>Current Number of Employees</u>
\$500,000	_____
\$750,000	_____
\$1,000,000	_____
\$1,500,000	_____
\$2,000,000	_____
\$5,000,000 (\$1,000,000 annual limit)	_____
Unlimited	_____

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-inpatient type services:

- a. Insured number
- b. Insured name
- c. Insured type
- d. Provider name
- e. Provider type (hospital IP, OP, professional, Rx, other)
- f. Admission Date
- g. Discharge Date
- h. Length of Stay
- i. Diagnosis Code
- j. Diagnosis description
- k. Amount billed
- l. Amount paid

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:**

**Faith Johnston  
Regional Vice President  
Summit Reinsurance Services, Inc.  
1366 Preserve Circle  
Golden, CO 80401  
PH: 720-746-1366 FX: 720-746-1613**