SummitRe

Insurance Carrier Request for Proposal

Reinsurance Effective Date:_____

Company Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Federal Tax ID#: _____ Date of Request: _____

Current Reinsurer:_____ Proposal Due Date:_____

EXCESS LOSS COVERAGE – D*ata and Information Request*

1. **Cover Letter –** Attach a letter with reinsurance options you would like to request or consider. In addition, please note any significant changes in provider contracts that may affect your past/future experience. Indicate any special concerns (*i.e.*, *covered services or contract limits*) you may have and want to make sure are addressed in your next reinsurance agreement.
2. **Provider Contracts –** Provide a copy of your current key hospital reimbursement arrangements. A summary matrix will be acceptable if it contains the reimbursement arrangements and any outlier provisions.
3. **4 Years of Claims Detail** – By reinsurance year, by line of business, for any member whose claims exceed 50% of the lowest requested deductible. It should also include data for the covered services being requested in the reinsurance proposal (i.e. inpatient only, inpatient and outpatient, or all services). Detail should include:
    a. Line item detail for each claim
    b. Column headings: Member ID (de-identified), Line of Business, Provider Name, Provider Type, Admit Date, Discharge Date, Length of Stay, Place of Service Code, Procedure Code, Revenue Code, DRG, Type of Bill Code, Primary Diagnosis Code, Diagnosis Description, Billed Charges, Allowed Charges, Paid Charges, Paid Date.
4. **4 Years of Member Months** – Provide this information by month by line of business for the past 4 years. Break lives by MSA if nationally distributed product.
5. **Historical Utilization/Costs** – Provide days-per-thousand and average-cost-per-day data for the past 3 years by member type.
6. **Copy of Current Reinsurance Agreement(s) along with reinsurance recovery reports from prior years**
7. **Disclose any material changes in the risk in the most recent 24 months that the underwriter should note, i.e. changes in policy benefits, provider contracts, networks, etc.**

I hereby certify that the information provided above is complete and accurate. I understand that in the event Zurich American Insurance issues the reinsurance coverage being requested, the contract 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, Zurich 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.
6920 Pointe Inverness Way, Suite 140
Fort Wayne, IN 46804
Phone: (260) 469-3000