

PROPOSAL INFORMATION FORM **101+**

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| Case Information |
| Group Name: | Effective Date: |
| Address: | City, State: | ZIP Code: |
| Number of Eligible Employees? | Number of Enrolling Employees? | Number of Valid Waivers? |
| SIC Code: | Nature of Business: |
| Does the group fund any portion of the deductible? [ ] Yes [ ] No If yes, what amount? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is the Employer Contribution for the:Employee \_\_\_\_\_\_\_\_\_ Dependent\_\_\_\_\_\_\_\_\_\_\_ |
| Does the group have claims experience? [ ] Yes [ ] No If Yes, did they make any plan changes last renewal? [ ] Yes [ ] NoIf Yes, please explain: |
| Are Early Retirees **<65** eligible for coverage? [ ] Yes [ ]  No If Yes, how many are covered? \_\_\_\_\_\_\_\_\_\_\_\_\_Are the contributions the same as FT [ ] Yes [ ]  No If no, what is the contribution? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are they offered the same benefits as full time? [ ] Yes [ ]  NoIf No, describe benefits: | Are Retirees **>65** eligible for coverage? [ ] Yes [ ]  No If Yes, how many are covered? \_\_\_\_\_\_\_\_\_\_\_\_\_Are the contributions the same as FT [ ] Yes [ ]  No If no, what is the contribution? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are they offered the same benefits as full time? [ ] Yes [ ]  NoIf No, describe benefits: |
| Current number of COBRA continues enrolled in the plan: \_\_\_\_\_\_\_\_ |
| Has group previously been insured with Aetna? [ ] Yes [ ] No Is the group currently insured with Aetna? [ ] Yes [ ] No If Yes, provide group/control number and line of coverage. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Funding: [ ] Fully Insured [ ] Self Insured [ ] Aetna Funding Advantage |
|  |
| Current Carrier Information |
| Carrier Name: | Years with Carrier: |
| Broker Information |
| Broker/Agency Name | Contact Name | E-mail Address |
| Request Broker Commission to be included in proposal: \_\_\_\_\_  |
| **General Agent Name: ARMS INSURANCE GROUP** |

1. Full Plan Designs
2. Current & Renewal Rates
3. Renewal Package
4. Claim experience (if available): provide 24 rolling months for medical & RX, and high claim report (by claimant) for same date range.
5. Standard Census (for groups 201+ **Enrolled**): complete census for all eligible Employees, Waivers and COBRA participants in Excel: Include First and Last Names, Dates of Birth, Home Zip codes, Genders, Medical Tiers, Medical Plan, and COBRA.
6. Membership Census(for groups 200 or fewer **Enrolled**): complete census for all eligible Employees ***and Dependents***, Waivers and COBRA participants in Excel: Include First and Last Names, Dates of Birth, Home Zip codes, Genders, Medical Tiers, Medical Plan, and COBRA. (Attachment 1)
7. For all groups under 200 &/or without experience: Group Medical Questionnaire required for firm rates.

Email **THIS Form** and all information above to: mfircak@armsins.com