

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 No  If 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  No  If 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  No  If 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