



**STOP LOSS REQUEST FOR PROPOSAL (RFP)**

Submitting Organization: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Address: \_\_\_\_\_  
 Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Broker: \_\_\_\_\_  
 Due Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Group Name: \_\_\_\_\_  
 Group Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Industry Description: \_\_\_\_\_ SIC Code: \_\_\_\_\_  
 If Hospital Group, Domestic Claims Reimbursement Percentage (%): Current \_\_\_\_\_ Requested: \_\_\_\_\_

Current Insurance Funding;  Fully Insured  Self Funded

Current Carrier(s): \_\_\_\_\_

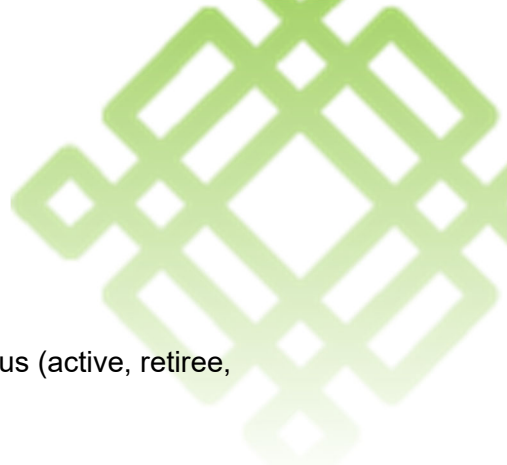
	EE	EC	ES	EF
Enrollment:	_____	_____	_____	_____
Current Rates:	_____	_____	_____	_____
Current Factors:	_____	_____	_____	_____
Renewal Rates:	_____	_____	_____	_____
Renewal Factors:	_____	_____	_____	_____

**SPECIFIC COVERAGE**

	Current	Requested
TPA	_____	_____
Network	_____	_____
Specific Deductible	_____	_____
Aggregating Specific:	_____	_____
Specific Contract Basis:	_____	_____
Specific Benefits Covered:	<input type="checkbox"/> Medical <input type="checkbox"/> Rx Card	<input type="checkbox"/> Medical <input type="checkbox"/> Rx Card
Annual Specific Maximum:	_____	_____
Lifetime Maximum:	_____	_____
Lasers (Name and Amount)	_____	_____

**AGGREGATE COVERAGE**

	Current	Requested
Aggregate Contract Basis:	_____	_____
Aggregate Benefits Covered:	<input type="checkbox"/> Medical <input type="checkbox"/> Rx Card <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Rx Card <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Annual Specific Maximum:	_____	_____



**The following information must be included to provide a quote:**

- Census** (Must have zip, DOB or age, coverage (EE|EF|ES|EC), status (active, retiree, cobra), gender, plan type (breakdown))
  
- Current year 50% report** showing DX, PX and paid amounts, trigger report, pre-cert report, LCM notes, pending and denied report
  
- Minimum two (2) prior plan years of large claims**
  
- If aggregate coverage requested, paid claim** experience (for all coverages included) for the current & prior two 2 full years
  
- Complete Plan Document** (Schedules of Benefit acceptable for quoting, but complete plan document will be required to bind coverage)

**Comments:**

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