KRMA®
KISMET RISK MANAGEMENT ASSOCIATES

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:	☐ Medical ☐ Rx Card	☐ Medical ☐ Rx Card
Annual Specific Maximum:	_____	_____
Lifetime Maximum:	_____	_____
Lasers (Name and Amount)	_____	_____
	_____	_____

☐ **AGGREGATE COVERAGE**

	Current	Requested
Aggregate Contract Basis:	_____	_____
Aggregate Benefits Covered:	☐ Medical ☐ Rx Card ☐ Dental ☐ Vision	☐ Medical ☐ Rx Card ☐ Dental ☐ Vision
Annual Specific Maximum:	_____	_____

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Indianapolis, IN 46250

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: