# REQUEST FOR PROPOSAL

Jasper Benefit Solutions, LLC

| EMPLOYER INFORMATION | |
|---|---|
| **Employer Group Name:** | **Proposed Effective Date:** |
| **Address:** | |
| **Years in Business:** | **SIC Code / Industry:** |

| CENSUS INFORMATION | | | | |
|---|---|---|---|---|
| **Total Number of Employees** | | | | |
| EE / Single | EE / Spouse | EE / Child(ren) | Family | Waived |
| | | | | |

**Please provide a census (Excel format is preferred), to include the following:**

- Date of Birth
- Gender
- Employee Zip Code
- Medical Tier Election

## COVERAGE INFORMATION

**Is the group currently Fully Insured or Self Funded?** ☐ **Fully Insured** ☐ **Self Funded**

| Fully Insured Medical | Prior Year | Current Year | Renewal Year |
|---|---|---|---|
| Carrier | | | |
| EE / Single Rate | | | |
| EE / Spouse Rate | | | |
| EE / Child(ren) Rate | | | |
| Family Rate | | | |

| Self Funded Medical | Prior Year | Current Year | Renewal Year |
|---|---|---|---|
| Stop Loss Carrier | | | |
| TPA | | | |
| Specific Deductible | | | |
| Aggregate Specific Deductible | | | |
| Specific Contract (e.g. 12/12, 12/15) | | | |
| Aggregate Contract (e.g. 12/12, 12/15) | | | |

| Current Rates | EE / Single | EE / Spouse | EE / Child(ren) | Family |
|---|---|---|---|---|
| Specific Rates | | | | |
| Aggregate Factors | | | | |
| Aggregate Premium | | | | |

| EXPERIENCE |
|---|
| ***For Dental, Vision and Other benefits, please duplicate RFP form for each benefit.** |
| **Please attach the following:** |
| • Monthly Paid Claims for the past three (3) years |
| • Enrollment history for the past three (3) years |
| • Shock loss claims in excess of 50% of the specific deductible or $10,000 for the past three (3) years |

| CONTACT INFORMATION – BROKER / TPA REQUESTING PROPOSAL | |
|---|---|
| **Name:** | |
| **Company:** | |
| **Phone:** | |
| **Email:** | |
| **Requested Due Date:** | |
| **Requested Commission:** | |

**PLEASE SEND ALL RFP SUBMISSIONS TO: UNDERWRITING@JASPERBENEFITSOLUTIONS.com**