SL HEALTH PLANS

Request for Proposal Form (RFP)

Thank you for your interest in SL Health Plans, providing benefits through national networks and claims administration, insured by highly rated national stop loss carriers. For us to fully evaluate your benefits program, please review and complete this form. Sections A&B should be filled out as best you can, together with the employee census in Section D. Please provide the census in Excel format. Please also provide copies of your current benefit plan summaries. If it is easier for you, please send us a copy or PDF of a recent monthly bill in lieu of filling out the rate information in Section C. This form has been designed to allow you to enter the data in electronic/Word format or hardcopy, but Word or Excel formats will accelerate our quote process..

Section A – Employer Quote Information: To be filled out by Employer

Legal Name of Employer	**Phone Number (xxx) xxx-xxxx**
	___
Address (Physical Address Only, no PO Box)	**City/State/Zip Code**
___	___

Type of Industry? (e.g. "Restaurant") ___	**SIC Code**	**Tax ID (EIN)**
	___	___

Business Entity Type:

☐ Sole Proprietorship ☐ General Partnership ☐ Limited Partnership

☐ Corporation ☐ Limited Liability Company ☐ Other (please explain)

Total number of employees ___	**Annual employee turnover %** ___	**Total number of benefit eligible employees:**	**Total number of employees waiving coverage:**
		___	- Have not met employer's eligibility requirements ___ - Insured under spouse/Parent ___ - Other (please indicate number and explain in Section D) ___

Does your current plan cover retirees (if applicable)? ☐	**Are any employees currently on disability?** ☐ ☐ ___	**Are there currently any employees on:** (please note number of employees here and indicate on the census in section D) - COBRA ___ - In COBRA election period ☐ - Medicare ☐

Contact person and title: ___

Contact person email:

Section B – Employee Eligibility Requirements: To be filled out by Employer

Who is eligible for coverage (for example, all full-time employees, non-union only, etc.): ___

Number of work hours per week to be considered eligible: ___

Employer contribution: (as a percentage or flat $ amount)

	As a Percent			**As a Flat $ Amount**
Health:	☐ percent employee	☐ percent dependent	OR	☐ Per employee

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Section C – Current Plan Information (If no current coverage in place, please ignore this section)

Please select what type of coverage you would like included in your quote?	Please provide the renewal dates for the plans you are requesting quotes for:	What month/year would you potentially be joining the program?
Medical: ☐ Dental: ☐ Vision: ☐ Life & Disability: ☐	Medical: ___ Dental: ___ Vision: ___ Life & Disability: ___	Medical: ___ Dental: ___ Vision: ___ Life & Disability: ___

Are your plan(s) fully insured, or do you self-fund? (if self-funded, please complete the last question of this section)	Do you currently provide deductible reimbursement to your employees? If so, please describe this process.	Plan deductible(s) reset on: Plan Year: ☐ Calendar Year: ☐

Have you had 3 or more carriers in the last 5 years? Yes ☐ No ☐ If, yes, please explain

Please provide your current and renewal (if available) monthly premium rates for each medical plan option. Please also provide each plan's corresponding Summary/Outline of Benefits as part of your RFP submission.

Current Rates (by Coverage Tier)	Carrier: ___ Plan 1 Name: ___	Carrier: ___ Plan 2 Name: ___	Carrier: ___ Plan 3 Name: ___	Carrier: ___ Plan 4 Name: ___
Employee Only	___	___	___	___
Employee + Spouse	___	___	___	___
Employee + Child(ren)	___	___	___	___
Family	___	___	___	___

Renewal Rates (by Coverage Tier)	Carrier: ___ Plan 1 Name: ___	Carrier: ___ Plan 2 Name: ___	Carrier: ___ Plan 3 Name: ___	Carrier: ___ Plan 4 Name: ___
Employee Only	___	___	___	___
Employee + Spouse	___	___	___	___
Employee + Child(ren)	___	___	___	___
Family	___	___	___	___

Please provide your current and renewal (if available) monthly premium rates for each dental plan option.

	Current Rates Carrier: ___ Plan 1 Name: ___	Current Rates Carrier: ___ Plan 2 Name: ___	Renewal Rates Carrier: ___ Plan 1 Name: ___	Renewal Rates Carrier: ___ Plan 2 Name: ___
Employee Only	___	___	___	___
Employee + Spouse	___	___	___	___
Employee + Child(ren)	___	___	___	___
Family	___	___	___	___

If your plan is self-funded, please provide a breakdown of your administrative fees as well as provide a summary of your stop-loss coverage.

Contract basis (e.g. 12/12, 15/12, 18/12, and 12/15)	
Aggregate level (E.G. 125%)	
Specific Stop Loss Deductible	
Aggregate Liability	
Total Administrative Costs (PEPM)(Admin, Networks etc.)	

Stop Loss Premium (PEPM)	Specific Premium	Agg Prem. ___ Agg Factors
Employee Only	___	___
Employee + Spouse	___	___
Employee + Child(ren)	___	___
Family	___	___

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Section D – Employee Census Information

Please complete embedded excel spreadsheet which asks for the following data:

*ALL benefit eligible employees/retirees PLUS
*ALL current enrollments PLUS
*ALL waiving coverage (please indicate reason for waiver) PLUS
*Those Active on COBRA or in COBRA election period

Please Include the following data:
Full Name of the Participant
Gender
Date of Birth (DOB)
Coverage Tier (ie - Single or Employee, EE + Spouse or SP, EE + Child(ren), Family
Zip Code
Current Plan Enrollment
:
*Those employees waiving coverage ("waived")
*Those employees who are currently on disability ("disabled")
*Those employees currently in Waiting Period ("waiting period")
*Those active on COBRA or in COBRA election period ("COBRA" or "Pending COBRA")

Please note, the above embedded file automatically saves within this word document. Upon completion of the spreadsheet, simply exit excel and your entries/changes will be saved. To transmit to us, please save this entire Word document and send via email

Section E – Group Experience & Plan Design

For larger employer groups, historical premium and claims information ("Experience") is available from the current carrier either upon request or provided at regular intervals throughout the contract year. If your group receives premium and claims information, please provide at least 2 years of experience under the following fields:

*Premiums and Claims (Medical and Pharmacy on monthly basis along with corresponding monthly subscriber enrollment)
*Plan designs (for each plan) in place at time of claims data
*Large claims report (i.e. claims in excess of $25,000)
*Please indicate any changes in network and/or carrier that have occurred within the last 2 years
*If dental claims are included, please separate from medical

If you are currently in a self-insured arrangement and seeking such an arrangement, please additionally provide:

*Large Claims (claims greater than 50% of current or lowest proposed specific deductible)
*Details of changes to benefits, provider networks, specific deductible / contract type, aggregate contract type or any other change that would have impacted the payment of claims

Section F- Checklist

Please use this section as a checklist to ensure you have provided the necessary information requested. In doing so, we can work towards providing your group a quote in a timely fashion.

Section A	**Section B**	**Section C**	**Section D**	**Section E** (if applicable)
Are all questions answered? ☐	Are all questions answered? ☐	Are all questions answered? ☐	Is census complete as outlined? ☐	Is "experience" data provided as outlined? ☐
		Are plan(s) Summary/Outline of Benefits included? ☐		If self-funded, is additional data provided? ☐

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