

LARGE GROUP / ALTERNATE FUNDING REQUEST FOR QUOTE & CENSUS TEMPLATE

Complete and email to sheplerfear@dickerson-group.com
or fax to 1-888-360-7342 (916-960-0321)

SHEPLER & FEAR
GENERAL AGENCY
A Division of



Broker Information

Date: _____ Producer Name: _____

Agency Name: _____

Agency Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Telefax: _____

Email: _____ Current Broker of Record? Yes No

Group Information

Group Legal Name: _____

Group DBA Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Key Contact: _____ Title: _____

Telephone: _____ Telefax: _____

Email: _____ Years In Business: _____

Nature of Business: _____ SIC Code: _____

Proposed Effective Date: _____ Waiting Period: _____

No. Eligible Employees: _____ No. COBRA Employees: _____ No. Ineligible Employees: _____

Employer Contribution for Employee Only: _____ for Dependents: _____

Are Retirees Offered Coverage? Yes No Common Ownership with other companies? Yes No

Medical Plan Information – Five Year Carrier History

Year	Carrier Name(s)	Type(s) of Coverage	Time Period
1			
2			
3			
4			
5			

If **KAISER PERMANENTE** is currently offered: Will Remain Total Replacement

Ancillary Plan Information – Five Year Carrier History

Year	Carrier Name(s)	Type(s) of Coverage	Time Period
1			
2			
3			
4			
5			

Health & Coverage Questions

1. Has any covered person in the group incurred <u>claims in excess of \$15,000</u> in the last 12 months? If yes, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are there any <u>currently disabled</u> persons in the group? If yes, please provide number of disabled persons:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are there any catastrophic or other <u>serious medical conditions</u> , including pregnancies, current hospital-confined or not-active-at-work persons in the group? If yes, please provide details including number of current pregnancies:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are all employees covered by <u>workers' compensation insurance</u> ? If no, please provide number of employees not covered by workers' compensation insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any owner or principal filed <u>bankruptcy</u> with the past 7 years, or known to be planning to file for bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does employer currently <u>reimburse employees</u> for any part of their normal out of pocket costs? If yes, please describe arrangement (i.e. FSA, HAS, HRA, MERP, etc.):	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Items Needed for Quote (attached)

A. Copy of most recent <u>monthly billing statement</u> from current carrier(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Copy of <u>upcoming plan year carrier(s) renewal</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Copy of <u>current and prior three years carrier(s) renewal</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Copy of <u>current year and prior three years paid claims report</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Copy of <u>current year and prior three years shock loss claim report</u> (diagnosis, amount, date, prognosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. If currently self-funded, copy of <u>current and prior three years aggregate claim/loss report</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. If currently self-funded, copy of current year <u>stop loss insurance policy</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. If currently self-funded or level-funded, copy of current year <u>administrative services agreement</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. Copy of current <u>Plan Document, Summary Plan Description or Certificate of Coverage</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Requested Date That Quote/Proposal is Needed:

Employee Census Template

(please provide in MS Excel or Excel Compatible format)

Each Column Heading:

A) Employee Last Name, First Name
B) Employee ID Number
C) Employee Date of Birth
D) Employee Gender
E) Employee Residential Zip Code
F) Employee Class (Salary, Hourly, Management, Union, etc.)
G) Employee Annual Earnings (if Disability Coverage is quoted)
H) Employee Date of Hire
I) Employee Status (Active, COBRA, Retired)
J) Medical Coverage Carrier
K) Medical Coverage Enrollment Code *
L) Dental Coverage Enrollment Code *
M) Vision Coverage Enrollment Code *
N) Life/AD&D Benefit Amount
O) Disability Benefit Amount
P) Spouse Age or Date of Birth
Q) Children Ages or Dates of Birth

K, L, M * Enrollment Codes for Medical, Dental, Vision coverage:

- EE = Employee Only
- ES = Employee & Spouse
- EC = Employee & Child(ren) + No. Children
- EF = Employee & Family + No. Children