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*

Dickerson Insurance Services AN ALERA GROUP COMPANY

Broker Information

Date: ________________ **Producer Name:** ____

Agency Name: ____

Agency Address: ____

City: _________________________________ **State:** ________________ **Zip Code:** ____________________

Telephone: _____________________________ **Telefax:** ____

Email: ____ **Current Broker of Record?** ☐ Yes ☐ No

What Do You Want Quoted: ☐ HDHP/HRA ☐ Level-Funded ☐ Self-Funded ☐ Benefit Captive ☐ Other: ____________

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

Additional Items Needed for Quote (attached)

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

Requested Date That Quote/Proposal is Needed: ________________________________

Other Instructions/Requests: ____

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Questions? Call the Alternative Funding Department at 1-877-361-7342

SHEPLER & FEAR GENERAL AGENCY A Division of Dickerson Insurance Services AN ALERA GROUP COMPANY

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
Lastname, Firstname	**ID No.**	**Date of Birth**	**Gender**	**Residential Zipcode**	**Class**	**Annual Earnings**	**Date Of Hire**	**Status**	**Medical Carrier**	**Medical Enroll Code***	**Dental Enroll Code***	**Vision Enroll Code***	**Life & AD&D Benefit**	**Disability Benefit**	**Spouse Age or DOB**	**Children Ages or DOB's**