Dickerson Insurance Services AN ALERA GROUP COMPANY *Authorized General Agent*

Alternative Funding Division

• Group HRA • Level-Funding •
• Self-Funding/Benefit Captive • Ancillary Exchange •

REQUEST FOR AN ALTERNATIVE FUNDING PROPOSAL

Proposal For: ☐Group HRA ☐Level-Funding ☐Self-Funded/Benefit Captive ☐Ancillary Exchange

Date Submitted: _____ **Date Needed:** _____

Part 1: BROKER INFORMATION

Producer Name: _____ **Agency Name:** _____

Agency Address/City/State/Zip: _____

Telephone: _____ **Telefax:** _____

Email Address: _____

Current Broker of Record: ☐ Yes ☐ No **Dickerson Sales Executive:** _____

Part 2: BASIC GROUP INFORMATION

Legal Name: _____

DBA Name: _____

Physical Address/City/State/Zip: _____

Mailing Address if different: _____

Key Contact Name: _____ **Title:** _____

Telephone: _____ **Telefax:** _____

Email Address: _____

Nature of Business: _____ **SIC Code:** _____ **Tax ID No.:** _____

Proposed Effective Date: _____ **Waiting Period:** _____

Employer Contribution for Employees: _____ **Employer Contribution for Dependents:** _____

No. Eligible Employees: _____ **No. Eligible Employees in Calif.:** _____ **No. COBRA Employees:** _____

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

Are group health benefits currently offered? ☐ Yes ☐ No **Group health renewal date:** _____

Workers' compensation Insurer: _____ **Workers' compensation renewal date:** _____

If *KAISER PERMANENTE* is currently offered: ☐ Will remain in place ☐ Total replacement

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

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Part 3: ADDITIONAL ITEMS NEEDED FOR QUOTE	**Check if attached**
Member Level Underwriting/Enrollment Census **(includes dependent DOB, address, ID/SSN)** **(See attached excel template)**	☐
Copy of most recent *monthly carrier billing statement(s)*	☐
Copy of *carrier renewals* (upcoming, current & prior two years)	☐
Copy of current *Plan Document*, *Summary Plan Description* or *Certificate of Coverage*	☐
If currently FULLY INSURED, *shock loss claim history* (amount, diagnosis, date, prognosis)	☐
If currently FULLY INSURED, *paid claims history* for current and prior plan year	☐
If currently FULLY INSURED, *paid premium history* for current year and prior plan year	☐
If currently SELF-FUNDED, *aggregate claim/loss report* for current and prior three years	☐
If currently SELF-FUNDED, *specific stop loss claim report* for current and prior three years	☐
If currently SELF-FUNDED, copy of current year *stop loss insurance policy*	☐
If currently SELF-FUNDED, copy of current *administrative services agreement*	☐

Part 4: EMPLOYER HEALTH & COVERAGE QUESTIONNAIRE (Verified by Employer)	**Yes**	**No**
#1: To your knowledge, has any covered person in the group incurred health **claims more than $15,000** in the **last 12 months**? If yes, please provide known details (date, diagnosis, prognosis, dependent status) below:	☐	☐
#2: Are there any **currently disabled persons** in the group? If yes, please provide number of disabled persons:	☐	☐
#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 the number of current pregnancies below:	☐	☐
#4: Are all employees covered by **workers' compensation insurance**? If no, please provide number of employees not covered by workers' compensation insurance:	☐	☐
#5: Has any owner or principal filed **bankruptcy** within the past seven (7) years, or known to be planning to file for bankruptcy?	☐	☐
#6: Does employer currently **reimburse employees** for any part of their normal out-of-pocket medical costs? If yes, please describe arrangement (i.e., FSA, HSA, HRA, MERP, etc.) below:	☐	☐