Vendor Information

Vendor Information	Vendor Name
	Response Required
Sales Executive	
Full Name:	
Title:	
Location Address:	
Phone Number:	
Email Address:	
Financial Information	
What is the legal name of the underwriting unit for this proposal?	
What is the current A.M. Best Rating?	
As of what date?	
What is the current Standard & Poors Rating?	
As of what date?	
General Information	
Yes/No - Are you able to offer and administer the current plan provisions for:	
Accident Coverage	
Hospital Indemnity Coverage	
Are the proposed rates net-of-commissions?	
If not, explain any commissions embedded in the proposed plans.	
Additional comments on proposed rates	

Accident Plan

	Inforce Plan Lives	Monthly Rates	Vendor Name Required Initial Quotation
Accident Plan			
Employee	2900	$4.56	
Employee+Spouse	814	$8.74	
Employee+Child(ren)	677	$9.70	
Family	1385	$12.16	
Rates Monthly Cost	5776	$43,747	$0
Rates Annual Cost		$524,962	$0

	Vendor Name & Responses
Rate Information	
Rate Guarantee End Date	
Describe underlying rate assumptions:	
a) Minimum enrollment assumptions:	
b) Enrollment deviations +/- 15%:	
d) Multi-line Discount	
Rate Caveats	
Confirm Rates Include Requested No Commissions	

Accident Plan

	Inforce Plan - MetLife	Vendor Name & Responses
General Information	**Accident**	**Accident**
Eligibility	All Active Employees, in parmanent position, working 20+ hours for at least 6 months of the year	
Effective Date	1 month and 1 day after date of hire	
Waiting Period	None	
Contributions	100% Voluntary	
Injuries		
Fractures	$50-5,000	
Dislocations	$100-3,200	
Second and Third Degree Burns	$100-6,400	
Concussions	$200	
Cuts/Lacerations	$25-400	
Eye Injuries	$200	
Medical Services & Treatments		
Ambulance	$200-750	
Emergency Care (varies depending on location of care)	$50-150	
Non-Emergency Care	$50	
Physician Follow-Up	$50	
Therapy Services (including physical therapy)	$25	
Medical Testing Benefit	$100	
Medical Appliances	$50-500	
Inpatient Surgery	$100-1,000	
Dismemberment Loss & Paralysis		
Dismemberment Loss & Paralysis	$5,000-10,000	

Hospital Indemnity Plan

	Inforce Plan Lives	Monthly Rates	Vendor Name Required Initial Quotation
Hospital Indemnity Plan			
Employee	1977	$8.38	
Employee+Spouse	746	$13.30	
Employee+Child(ren)	373	$17.32	
Family	730	$22.40	
Rates Monthly Cost	3826	$49,301	$0
Rates Annual Cost		$591,617	$0

Vendor Name & Responses

	Vendor Name & Responses
Rate Information	
Rate Guarantee End Date	
Describe underlying rate assumptions:	
a) Minimum enrollment assumptions:	
b) Enrollment deviations +/- 15%:	
d) Multi-line Discount	
Rate Caveats	
Confirm Rates Include Requested No Commissions	

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Hospital Indemnity Plan

	Inforce Plan - Voya	Vendor Name & Responses
General Information	**Hospital Indemnity**	**Hospital Indemnity**
Eligibility	All Active Employees, in permanent position, working 20+ hours for at least 6 months of the year	
Effective Date	First of the month following date of hire	
Waiting Period	None	
Contributions	100% Voluntary	
Treatment for an Accident		
In-patient hospital stay Confinement must occur within 180 days of the accident	Non-ICU: $200 a day for up to 180 days ICU: $400 a day for up to 30 days	
In-patient rehab Stays must occur immediately following hospital confinement and within 365 days of the accident	$100 a day, up to 15 days per accident and 30 days per calendar year	
Treatment for an Illness		
In-patient hospital stay Paid per sickness	Non-ICU: $200 a day for up to 180 days ICU: $400 a day for up to 30 days	

Critical Illness Plan

	Monthly Rates	Vendor Name Required Initial Quotation
Critical Illness		
Employee		
Employee+Spouse		
Employee+Child(ren)		
Family		
Rates Monthly Cost	#REF!	#REF!
Rates Annual Cost	#REF!	#REF!

	Vendor Name & Responses
Rate Information	
Rate Guarantee End Date	
Describe underlying rate assumptions:	
a) Minimum enrollment assumptions:	
b) Enrollment deviations +/- 15%:	
d) Multi-line Discount	
Rate Caveats	
Confirm Rates Include Requested No Commissions	

	Critical Illness Illustration			
Benefit Highlights				
Eligibility				
Benefit Amount				
Covered Conditions				
Cancer Diagnosis				
Heart Attack / Stroke				
Bone Marrow Transplant				
Cancer Treatment & Care				
Wellness Benefit				
Recurrence				
Separation				
Pre-Existing Conditions Exclusion				
Required Employee Participation				
Health Advocate Benefit				
Monthly Rates: Composite				
Monthly Rates: Non-Tobacco				
Rates (per $10,000)	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Age 0-24				
Age 25-29				
Age 30-34				
Age 35-39				
Age 40-44				
Age 45-49				
Age 50-54				
Age 55-59				
Age 60-64				
Age 65-69				
Age 70-74				
Age 75-79				
Age 80-84				
Age 85+				
Monthly Rates: Tobacco				
Rates (per $10,000)	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Age 0-24				
Age 25-29				
Age 30-34				
Age 35-39				
Age 40-44				
Age 45-49				
Age 50-54				
Age 55-59				
Age 60-64				
Age 65-69				
Age 70-74				
Age 75-79				
Age 80-84				
Age 85+				
Rate Guarantee				

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Accident & Hospital Indemnity & Critical Illness Questionnaire

	Vendor Name
	Response Required
	Initial Quotation
Financial Information > Financial Overview	
Vendor's minimum participation requirements for:	
Accident	
Hospital Indemnity	
Vendor's minimum employer contribution levels (confirm 0% employer contribution)	
Confirm that proposed rates will not be subject to change based on differences between actual enrollment and underwriting information provided in this RFP.	
Outline any other assumptions that may result in a change to your proposal	
Financial Information > Proposed Rate Development Method	
What rate guarantee are you offering for this client? (request min of 3 years)	
Are you willing to offer a contingent guarantee (subject to an incurred loss ratio) in subsequent years beyond this initial period?	
If yes, provide the loss ratio and the Maximum Increase	
Loss Ratio:	
Maximum Increase:	
Vendor's credibility factors used to generate quote	
Pooling level	
Trend	
Vendor's expected or targeted loss ratios	
Implementation credit	
Do you offer an Implementation Credit?	
Amount:	
Notes:	
Financial Information > Invoicing	
Indicate the length of the grace period you will permit for late payment of fees/premiums	
Indicate interest charge applied for late premium payment	
Financial Information > Underwriting Assumptions	
Is your proposal contingent on the client's acceptance of any other lines of coverage?	
Are you offering any multi-line discounts?	
Non-Financial Information	
Where will customer service staff be located and what are their hours of operation (include time zone)?	
In a few sentences, explain the customer service options available to members who have questions about this coverage.	
In a few sentences, explain your claim filing process. (Electronic or paper. Telephonic or web. Submission support.)	
In a few sentences, explain how your organization handles incomplete claim filings.	
In a few sentences, explain the customer service options available to the State benefits staff for escalated issues.	
What are the responsibilities of the client in supporting the communications, enrollment and ongoing administration of the plan(s)?	
How do you propose to communicate the plan to employees? Will you provide both hard-copy and electronic communications materials?	
After enrollment, does the employee receive a welcome kit?	
What enrollment methods are available from your organization?	

What open enrollment support does your organization provide to the client and potential members?	
Is the coverage portable?	
Do both policies include waiver of premium provisions?	
How many years has your company been offering Accident Insurance?	
Regarding Accident Coverage: What is the current total annual written premium, number of insureds, number of policies and/or certificates in-force and policy retention rate? Please distinguish between Group Certificate holders and Individual Policyholders if you offer both forms.	
How many years has your company been offering Hospital Indemnity Insurance?	
Regarding Hospital Indemnity: What is the current total annual written premium, number of insureds, number of policies and/or certificates in-force and policy retention rate? Please distinguish between Group Certificate holders and Individual Policyholders if you offer both forms.	
Are your products HSA and/or HRA compatible? Please state reasons why your product is or is not compatible with an HSA or HRA.	
Identify any other deviations from current plan provisions.	
Will you agree to design communications to communicate the program to members?	
Will you prepare Summary Plan Descriptions and Plan Summaries by May 1st of each year in order to be available during the Open Enrollment Period?	
Will you provide the State with quarterly and annual reporting? Attach sample reports to your proposal as: "VendorName_QuarterlyRptSample" and "VendorName_AnnualRptSample".	
Did you attach references as "VendorName_References"?	
Did you attach your implementation plan as "VendorName_Implementation Timeline"?	

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Performance Guarantees

	Vendor Name
	Response Required
	Initial Quotation
Performance Guarantees	
Implementation and Annual Open Enrollment	
Claims Administration	
Customer Service	
Member Satisfaction	
Reporting	