Coastal TPA - Request for Proposal

Email requests to: proposal@coastalmgmt.com / Fax requests to: (831) 754-3830
Mail requests to: PO Box 80308, Salinas, CA 93912 / Call toll free: 1-800-564-7475

Submitting Broker Name: _____

Submitting Broker Phone: _____ **Fax:** _____

Submitting Broker Email: _____

Business Name: _____

Nature of Business/SIC Code: _____ **No. EE's:** _____*

Mailing Address: _____

City: _____ **County:** _____ **State:** ____ **Zip:** _____

Telephone: _____ **Telefax:** _____

Email Address: _____

**If more than 50 employees, please complete the Large Group Risk Assessment form in addition to this one*

Requested Proposal for an:

Effective date: _____

- ■ Insured PPO Plan
- ■ High Deductible/HRA Plan
- ☐ Self Funded with Excess Loss
- ■ Administrative Services Only

Employee / Dependent Census

Employee Name:	Class:	Employee Age/DOB:	Sex:	Coverage Type*:	No. Children:	Spouse's Age/DOB:	Owner, Officer or Partner?	Residence Zipcode:	Monthly Earnings for Disability Insurance Coverage:

*Coverage Type: EE = Employee Only ES = Employee & Spouse EC = Employee & Child(ren) EF = Employee & Family

Allied National Wellness Horizons Major Medical Plans

Premium Advantage PPO series of plans-

Calendar Year Deductible:

☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
☐ $3,000 ☐ $3,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $15,000

Coinsurance (network/non-network):

☐ 100%/70% ☐ 80%/50% ☐ 50%/50%

Coinsurance Out-of-Pocket Maximum (network/non-network):

☐ $0/$3,000 ☐ $0/$6,000 ☐ $1,500/$3,000 ☐ $2,000/$4,000
☐ $2,500/$5,000 ☐ $3,000/$6,000 ☐ $4,000/$8,000 ☐ $5,000/$10,000

Doctor Office Visit Benefit (deductible & coinsurance waived):

☐ None (visits are subject to deductible and coinsurance, not a first dollar benefit)
☐ Unlimited annual visits ☐ 4 times annually ☐ 2 times annually
☐ $30 copay ☐ $35 copay ☐ $40 copay ☐ $50 copay ☐ HRA (self funded)

Prescription Drug Card Benefit (deductible & coinsurance waived):

☐ None (Drug Discount Card only) ☐ Deductible Integrated ☐ HRA (self funded)
☐ $0 deductible, unlimited benefit ☐ $150 deductible, unlimited benefit or ☐$1,500 limited

Other Optional Benefits:

☐ Occupational Coverage ☐ Pregnancy as any other illness ☐ $500 Supplemental Accident

Core Value PPO series of plans-

Calendar Year Deductible: ☐ $3,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Prescription Drug Card Benefit: ☐ None (discount card only) ☐ Deductible Integrated
☐ Generic/Formulary with $_____ deductible on Brand Name*
* *Rx Deductible options of $150, $250, $350, $500 are waived for Generic/OTC*

Supplement Benefits: ☐ Employer paid ☐ Voluntary ☐ Both
☐ $1500 Oupatient ☐ $2500 Outpatient ☐ $3500 Outpatient
☐ $2500 Inpatient ☐ $5000 Inpatient ☐ HRA (Self Funded)

Other Optional Benefits: ☐ Occupational Coverage ☐ Pregnancy as any other illness

Health Savings series of plans-

Calendar Year Deductible:

☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000

Coinsurance (network/non-network) & Out-of-Pocket Maximum (network/non-network):

☐ 100%/70% with OOP of: ☐ $0/$3,000 ☐ $0/$6,000
☐ 80%/50% with OOP of: ☐ $1,500/$3,000 ☐ $2,000/$4,000
☐ $2,500/$5,000 ☐ $3,000/$6,000

Prescription Drug Card Benefit (deductible & coinsurance waived):

☐ None (outpatient prescriptions are NOT a covered expense, but a Drug Discount Card is provided)
☐ Deductible Integrated (outpatient prescriptions are covered, subject to deductible & coinsurance)

Other Optional Benefits: ☐ Occupational Coverage ☐ Pregnancy as any other illness

Allied National Cost Saver Medical Plans

Allied Cost Saver series of plans-

Plan: ☐ 500 Value ☐ 750 Basic ☐ 1000 Standard ☐ 1500 Superior

Calendar Year Deductible: ☐ $250 ☐ $500

Prescription Drug Card Benefit (deductible & coinsurance waived):

- ☐ Generic Only ($15 copay with unlimited generic and discount card for brand name)
- ☐ Formulary with unlimited generic, $75 deduct., $500 brand name limit ($3/$10/$30/$50/50% copays)
- ☐ Formulary with unlimited generic, $150 deduct., $1,500 brand name limit ($3/$10/$30/$50/50% copays)

Other Optional Benefits:

- ☐ Occupational Coverage ☐ Pregnancy as any other illness

Allied National Ancillary Benefit Plans

Allied Life & Disability series of plans-

Life/AD&D Benefit: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: _____

Disability Benefit: ☐ Short Term ($_____ weekly benefit for max. of _____ weeks after ____day wait)

☐ Long Term ($_____ monthly benefit max for _____months after ____day wait)

Allied Dental Design series of plans-

Annual Maximum Benefit: ☐ $1,000 ☐ $1,500 ☐ $2,000

Deductible: ☐ $50 Calendar Year ☐ $75 Calendar Year ☐ $100 Lifetime

Takeover: ☐ Yes ☐ No **Enhanced Option:** ☐ Yes ☐ No

Orthodontia: ☐ Yes ☐ No **Orthodontia Takeover:** ☐ Yes ☐ No

Employee Class Definitions (if used), Contributions & Waiting Periods

Employee Class 1 (description: _____)

-Contribution: Employer pays $_____ or _____% of Employee Cost and $_____ or _____% of Dependent Cost

-Waiting Period: Coverage effective first of the month after _____ days following date of full time hire

-Full time definition: _____ hours worked per week / Other: _____

Employee Class 2 (description: _____)

-Contribution: Employer pays $_____ or _____% of Employee Cost and $_____ or _____% of Dependent Cost

-Waiting Period: Coverage effective first of the month after _____ days following date of full time hire

-Full time definition: _____ hours worked per week / Other: _____

Employee Class 3 (description: _____)

-Contribution: Employer pays $_____ or _____% of Employee Cost and $_____ or _____% of Dependent Cost

-Waiting Period: Coverage effective first of the month after _____ days following date of full time hire

-Full time definition: _____ hours worked per week / Other: _____

**If this is a group with 51+ employees please complete the Large Group Risk Assessment form*

Large Group Risk Assessment

Company Name: _____

City/State/Zip: _____

Type of Business: _____ SIC Code: _____

Telephone: _____ Fax: _____

Effective Date: _____ Years in Business: _____

No. F/T Employees: _____ No. P/T Employees: _____

Other **Locations and no. of employees** at those locations: _____

_____

Has owner or principal filed **bankruptcy** within the past 7 years? _____

Does employer provide benefits–

-To **Part-Time** Employees? __Yes __No

-To **1099** Employees? _____

-To **Seasonal** Employees? _____

-To **Retired** Employees? __Yes __No

-To **Leave-of-Absence** Employees? __Yes __No

-To **Owners not active** at work? __ Yes__No

Are there any current **COBRA** participants covered? _____If so, how many? _____

Are there any currently **disabled/pregnant** employees or dependents? _____ If so, how many? _____

If so provide the date disability began, description of the condition and prognosis/delivery date on page 2 of this form

Has any covered person received **medical benefits in excess of $25,000** in the last 12 months? _____

If so provide amount of benefits paid, date of benefits paid, diagnosis and prognosis of condition on page 2 of this form

Will coverage be offered alongside of **another carrier**? _____ If so, who: _____

Will the group be **self funding** any benefits, including **contributions to an H.S.A.** or **reimbursements from an H.R.A.**? _____ If so, describe the arrangement: _____

_____

Are any employed persons **excluded from workers compensation** insurance? _____ If so, who: _____

CURRENT RATES

Carrier: _____

Plan Type/Name: _____

Effective Date: _____

Emp/Only: $_____ Emp/Spouse: $_____

Emp/Child:$_____ Emp/Family: $_____

RENEWAL RATES

Carrier: _____

Plan Type/Name: _____

Effective Date: _____

Emp/Only: $_____ Emp/Spouse: $_____

Emp/Child:$_____ Emp/Family: $_____

___Provide a copy of the most recent **monthly billing statement** which verifies rates, premium and covered persons

___Provide a copy of the **schedule of benefits summary** for all current plan(s) offered

___Provide an **employee census** which includes: Name, Gender, Age/DOB, Zipcode, Dependent Status, Classification

UNDERWRITING DETAILS

COBRA Continuation Coverage

Name: Date COBRA Began: Name: Date COBRA Began:

A._____ E._____

B._____ F._____

C._____ G._____

D._____ H._____

Currently Disabled, Pregnant or Leave of Absence

Name: Date Condition Began: Work Related?: Diagnosis: Prognosis:

A._____

B._____

C._____

D._____

"Shock Loss" Claims In Excess of $25,000 Last 36 Months

Name: Date of Loss: Amount : Diagnosis: Prognosis:

A._____

B._____

C._____

D._____

Other Information

To the best of your knowledge, please indicate **other specified conditions** which have been incurred during last **12 months** including: AIDS, Alcohol Abuse, Arthritis, Back/Neck, Blood, Joint, Brain, Cancer/Tumor, Cardiovascular, Diabetes, Drug Abuse, Epilepsy, Ears/Eyes, Emphysema/Pulmonary, Heart Disease, Hi Risk Pregnancy, Infertility, Intestines, Kidney, Liver, Lungs, Lupus, Mental/Nervous, Migraines, Neurological, Pancreas, Skin, Stomach, Stroke/Paralysis, Venereal, Other (detail):

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