Promise℠ Health Plan

Request for Stop-Loss Proposal

Policyholder

Company name*_____

Address*_____

City*_____ State*_____ ZIP*_____

Effective date*_____ Date needed*_____ SIC code*_____ Industry*_____

Third-party administrator*_____

Network*_____

Broker/Producer

Broker name*_____ License #*_____

Address*_____

City*_____State*_____ ZIP*_____

Commission*_____

Enrollment

Single count*_____ EE/SP*_____ EE/CH*_____ Family*_____

HMO count_____ PPO count_____ POS count_____

Retirees under 65_____ Over 65 and Medicare eligible_____

Plan Designs – *Please provide the following data:*

- Plan design(s) including current and proposed Schedule of Benefits, deductibles, copayments
- Current rates: Single_____ EE/SP_____ EE/CH_____ Family_____
- Current factors: Single_____ EE/SP_____ EE/CH_____ Family_____

Current Coverage ❑ Captive ❑ Traditional

Current funding method ❑ Fully insured ❑ Self-funded ❑ Other_____

Carrier_____ Third-party administrator_____

Contract basis ❑ 12/12 ❑ 12/15 ❑ 15/12 ❑ Other_____

Current Terms ❑ Current ❑ Renewal

Coverage ❑ Medical ❑ Rx ❑ Dental ❑ Specific ❑ Aggregate

Specific contract basis ❑ 12/12 ❑ 12/15 ❑ 15/12 ❑ Other_____

Deductible_____ TLO_____ NNL_____ Rate cap_____ Monthly accommodations_____

Aggregate contract basis ❑ 12/12 ❑ 12/15 ❑ 15/12 ❑ Other_____

***Required field**

Request to Quote ❑ Captive ❑ Traditional ❑ Specific stop-loss

Coverage ❑ Medical ❑ Prescription drug

Deductible(s) requested _____ _____

Contract basis ❑ 12/12 ❑ 12/15 ❑ 15/12 ❑ Other_____

❑ Annual maximum ❑ Lifetime maximum ❑ Unlimited

Aggregate Stop-Loss

Contract ❑ Medical ❑ Prescription drug ❑ Dental

Corridor % ❑ 120% ❑ 125%

Contract basis ❑ 12/12 ❑ 12/15 ❑ 15/12 ❑ Other_____

TLO_____ NNL_____ Rate cap_____ Monthly accommodations

Quote Requirements

- Employee census (Excel format) containing ZIP code, gender, date of birth, medical tier, network
- Current Plan Design Summary or SBC and any proposed plan design changes: Full SPD will be required to bind.
- 24–36 months of paid claims, large claim report, detailed large claims, pending claims, denied claims and renewals (if available)

Please note: All claim reports experience periods must match the paid claims experience.

Contract Details

Completed by_____

Organization Email_____

Comments

Please Submit to

Promise Health Plan
300 E. McBee Ave., Suite 501
Greenville, SC 29601

Email: info@PromiseHealthPlan.com
*Please note: **Subject line must include New Business RFP**. The words "confidential," "encrypt," or "secure" cannot be used.*

Phone: