

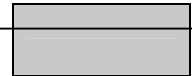


**indsey Associates
Insurance Services**



**New World
Insurance Services**

**SELF-FUNDED
HEALTH INSURANCE
BUSINESS OWNERS
OR
GROUPS
INFORMATION**



Business Owners Name: _____

Business Owners Address: _____

Business Owners: E-mail: _____

Phone: _____

Fax: _____

Website: _____

Group Name: _____

Group Address: _____

Multiple addresses (if applicable): _____

Group: E-mail: _____

Phone: _____

Fax: _____

Website: _____

Business or Group:

Nature of business and/or SIC Code: _____

Current Carrier(s): _____

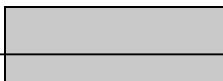
Current PPO(s): _____

Renewal/Anniversary Date: _____

Target Effective date for group: _____

(If target effective date is different from the renewal/anniversary date – why is the group or business owner shopping at this time?) _____

Due Date: _____





REQUIRED INFORMATION

Employee	Employee
Employee/Spouse	Employee/Spouse
Employee/Children	Employee/Children
Family	Family

Census of all employees giving coverage, age, sex, and zip code (with multi-tier breakdown, if applicable)

Dual plans involved? If so, indicate what the benefits are for each plan and which employees are electing the coverage: _____

Copy of complete schedule of current benefits, including:

- Deductible (in- and out-of-network)
- Coinsurance percentage (in- and out-of-network)
- Out-of-pocket maximum (in- and out-of-network)
Also, please indicate if the deductible is included in the out-of-pocket maximum.
- Prescription drug benefit. If no drug card is in place, are prescriptions covered the same as any other illness or are drugs not covered under the specific and aggregate?
- Doctor visit copay and emergency room copay.
- Hospital and surgical deductible, if any.

Commission schedule/compensation structure to be included in our proposal? _____

Plan design(s) requested? Or duplicate current benefits (as close as possible)? _____

Preferred PPO: _____

Employer contribution: employee _____ dependent _____

Participation level (must be at least 60%) _____

Is the group fully insured or self-funded? _____ FI _____ SF ***

*** If self-funded, 2-3 years of plan experience is required.

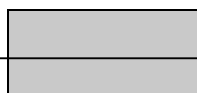
* Aggregate and specific claim reports.

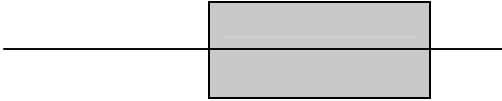
* If there are large claims, what is the prognosis?

Note: If the group is self-funded, the ESP plan is unable to provide run-in claim services.

Term Life insurance coverage is required. If the group currently has life coverage, please provide the life rates, census, and schedule of benefits.

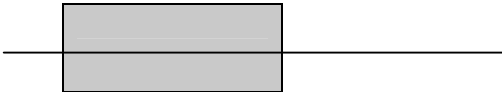
Life insurance rates _____ Life coverage schedule _____





**SELF-FUNDED
HEALTH PLAN
EMPLOYER INFORMATION**

EMPLOYER INFORMATION			
Employer Name			
Address			
City		State	Zip
Phone	Fax	E-Mail	
Multiple locations? (If Yes, list other locations below) <input type="checkbox"/> Yes <input type="checkbox"/> No			How Many?
Location #1 Name	Address		City,St
Location #2 Name	Address		City,St
Location #3 Name	Address		City,St
Location #4 Name	Address		City,St
CEO or Owner of Business			
Contact Person at Group			Phone
Federal Tax ID#	Nature of Business		SIC Code
Type of Business	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Church <input type="checkbox"/> Other :		
Plan Number 5 _____	Effective date of group:		
Total # of Employees	# of Eligible Employees	# of Employees Electing Coverage	
Billing Contract Person, Phone, Fax & E-Mail:			
Contact Name for Additional Divisions			
FORMER COVERAGE			
Name of Former Carrier		# of Yrs with Former Carrier	Effective date of Former Plan
Former Rates	Employee: \$ _____	Dependent: \$ _____	
Renewal Rates	Employee: \$ _____	Dependent: \$ _____	
Miscellaneous Notes:			





PROPOSED REINSURANCE INFORMATION:

Stop Loss Carrier	Rates	
Claim Factors	Specific Deductible	
Specific Contract Type	<input type="checkbox"/> 12/12 TSL	<input type="checkbox"/> 12/15
Aggregate Contract Type	<input type="checkbox"/> 12/12 TAL	<input type="checkbox"/> 12/15
Benefits Covered by Specific	<input type="checkbox"/> Medical	<input type="checkbox"/> Rx
Benefits Covered by Aggregate	<input type="checkbox"/> Medical	<input type="checkbox"/> Rx
Claim Funding	<input type="checkbox"/> Fund as Needed	<input type="checkbox"/> Maximum Funding
Aggregate Attachment Point	Minimum Aggregate Attachment Point	
Laser Specific: Name	SSN:	Specific \$

Current Life Insurance Information

Life Carrier	Life Policy Number
Life Schedule	AD&D Schedule
	Life Reduction Schedule

Eligibility & Contribution Information

Minimum Hours Needed	Employer Contribution Percentage: Employee	Dependent
Can an Employee have Life only?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Waiting Period: _____ days	Class I (_____)	
_____ days	Class II (_____)	

PPO Information (Select One) (please attach a copy of the proposed Schedule of Benefits)

PPO Plan
 Name of PPOs: _____ Locations: _____

INDEMNITY Plan

Other Benefits:

Life Insurance	<input type="checkbox"/> Amount \$ _____			
Supplemental Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dependent Life	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Terminal Liability	<input type="checkbox"/> Specific	<input type="checkbox"/> Aggregate	<input type="checkbox"/> Both	<input type="checkbox"/> None
Flex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	POP	<input type="checkbox"/> Yes <input type="checkbox"/> No

COBRA Information

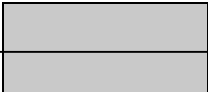
Do you have anyone on COBRA? Yes No How many? _____

List COBRA Employees Below and Dates of Termination (attach additional sheets if necessary).

Name 1	Address	City, ST
Name 2	Address	City, ST

Miscellaneous Information

Are there more than one level of Medical Benefits? Yes No If Yes, are they buy up? _____



Return to: F. Darrell Lindsey
PH: 866-937-7037
FX: 866-937-7010

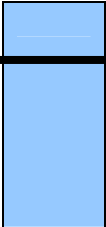


FAX BACK COVER SHEET

TO: 866-937-7010

FROM: _____

Phone: _____
FAX: _____
E-Mail: _____



TO: _____
Phone: 866-937-7037
FAX: 866-937-7010
E-Mail: fdl@arinsuranceservices.com



Comments: _____

