Lindsey 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: _____

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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 _____

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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) ☐ Yes ☐ 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 ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Governmental Entity ☐ Church ☐ 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 ☐ 12/12 TSL ☐ 12/15		
Aggregate Contract Type ☐ 12/12 TAL ☐ 12/15		
Benefits Covered by Specific ☐ Medical ☐ Rx		
Benefits Covered by Aggregate ☐ Medical ☐ Rx		
Claim Funding ☐ Fund as Needed ☐ 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? ☐ Yes ☐ 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	☐ Amount $_____						
Supplemental Life	☐ Yes	☐ No		Dependent Life	☐ Yes	☐ No	
Dental	☐ Yes	☐ No		Vision	☐ Yes	☐ No	
Terminal Liability	☐ Specific	☐ Aggregate	☐ Both	☐ None			
Flex	☐ Yes	☐ No		POP	☐ Yes	☐ 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

indsey and Associates
INSURANCE SERVICES

New World
Insurance Services

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:_____

_____

_____

_____

_____

_____

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