

**Information toward a Medical Stop Loss Proposal**

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| **General** | **Please Fill In:** |
| Broker/Contact Name: | **Fill In** |
| Group Name: | **Fill In** | Effective Date: | **Fill In** |
| City, State, Zip: | **Fill In** | Due Date: | **Fill In** |
| Type of Business: | **Fill In** | **SIC #** | **Fill In** |
| Subsidiaries – Locations (City/State): | **Fill In** |
| Commission %: | **Fill In** |

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| **Admin/Networks** | **Please Fill In:** |
|  | **Current** | **Proposed** |
| TPA: | **Fill In** | **Fill In** |
| PPO Network: | **Fill In** | **Fill In** |
| UR/LCM: | **Fill In.** | **Fill In** |

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| **Specific (Click on Boxes to Complete)** |  | **Aggregate (Click on Boxes to Complete)** |
| Contract Type: **Fill In** |  | Contract Type: **Fill In** |
| Coverage Includes: [ ]  RX  |  | Coverage Includes: [x]  RX [ ]  Dental  |
| Spec Deductible:**Fill In** |  | Current Agg Rates:**Fill In** |
| Current Spec Rates:**Fill In** |  | Current Agg Factors: **Fill In** |

\*MED Coverage automatically included

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| **Census/Benefits** | **Please Submit (Click on Boxes to Complete):** |
| Census Data to include:*(Excel Format)* | [ ]  Age/DOB [ ]  Zip code [ ]  Gender [ ]  Single/Family\* [ ]  COBRA/Retiree Designation [ ]  Plan Selection*\*If tiered rating desired, coverage designation to be given by tier*  |
| Schedule of Benefits | [ ]  Current [ ]  Proposed |

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| **Claims** | **Please Submit (Click on Boxes to Complete):** |
| NOTE: For each item, please include **Current and Prior two Years** | [ ]  Monthly Paid Claims for coverages being requested and monthly enrollment*\*Only Enrollment data needed if Agg Coverage not requested*[ ]  Claimants that have reached – or are expected to reach – 50% of the Specific Deductible amount[ ]  Detailed large Claim information – to include: diagnosis, prognosis and dollar amounts paid for **current** year.  |

**Please send all RFP submissions to:** **MSL.RFP@bhspecialty.com**

Our Underwriting Offices are located in Irvine, CA ▪ Indianapolis, IN ▪ Atlanta, GA