IACT medical trust
Your Partner for Municipal Health

Quoting Checklist for Groups with 2-49 Employees and Fully Insured

Thank you for your interest in the IACT Medical Trust. The Underwriters can begin working on a proposal when all checklist items are received and FormFire is completed by the benefit eligible employees. This includes employees who have waived coverage with the municipality. The Trust will create the FormFire account for your group. The requested information should be submitted to Wendy Glista via email at wglista@iactmedicaltrust.org or faxed to 765-464-6213. Wendy can be reached at 765-429-5000, ext. 257 should you have questions about a proposal.

	WHAT NEEDS TO BE SUBMITTED BY THE MUNICIPALITY	WHERE TO LOCATE REQUIRED ITEMS
☐	Copy of current medical plan design(s). The Plan Summary, Summary Plan Document (SPD) or Certificate of Coverage.	Current Carrier or Broker can provide if the City or Town does not have a copy on hand.
☐	Current year rates, rates for the two prior years and the renewal rates if available.	Current Carrier or Broker can provide. A copy of a monthly premium invoice for each year requested (current and prior two years) can also be submitted.
☐	Census- Excel spreadsheet of eligible employees including retirees & COBRA participants listing the following: full name, SSN, Gender, date of birth, Coverage tier (EE, ES, EC, F or waiving), zip code.(*If offering more than one medical plan identify plan each employee is participating in, PPO, HSA, etc.)*	This spreadsheet will need to be created by the Fiscal Officer or Human Resource Department's staff and electronically submitted to the IACT Medical Trust.
☐	Completion of FormFire. This is an online health insurance application. FormFire replaces the paper applications with an intelligent digital "Interview". It provides the medical information needed to prepare the proposal. The data is collected one time and stored year to year if updates are needed.	The Trust service Team will activate FormFire for a municipality upon receipt of the Employer Tax ID number. A welcome Letter with instructions will be sent to the main contact to distribute to eligible employees.

MUNICIPAL CONTACT AND MEDICAL BENEFIT INFORMATION	
City/Town of:	
Name of person responsible for managing employee benefits (health, dental, vision, life insurance):	
Address:	
Telephone number:	
Email:	
Federal Tax I.D.:	
Number of full-time employees and number of employees participating in the Medical plan:	Full-Time Employees _____ Medical Plan Participants _____
Requested Effective Date:	
Current Insurance Carrier (Anthem, Cigna, UHC, SIHO, Advantage, etc.):	
Number of Years with Current Carrier:	
Do the participant employees cost share in the medical premiums with an employee premium contribution?	☐ **YES** ☐ **NO**
If yes, what percentage or flat amount of the total monthly premium does the employee participant pay as the employee premium contribution?	EMPLOYEE:_____ EMPLOYEE/SPOUSE: _____ EMPLOYEE/CHILD(REN):_____ FAMILY:_____
Does the city/town currently offer a Health Savings Account (HSA) plan?	☐ **YES** ☐ **NO**
If yes, how much does the city/town contribute towards the HSA on an annual basis?	EMPLOYEE: $_____ EMPLOYEE/SPOUSE: $_____ EMPLOYEE/CHILD(REN): $_____ FAMILY: $_____