IACT medical trust
Your Partner for Municipal Health

Quoting Checklist for Groups of 50-99 Employees and Self-Funded

Thank you for your interest in the IACT Medical Trust. The Trust's Underwriters will begin the proposal process when all checklist items are received. The below requested information can 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 if you have any questions about the proposal process.

	WHAT NEEDS TO BE SUBMITTED BY THE MUNICIPALITY	WHERE TO LOCATE ITEMS
☐	Copy of current medical plan design(s). The Plan Summary or Summary Plan Document (SPD) is acceptable.	The Third Party Administrator (TPA) can provide if the City or Town does not have a copy on hand.
☐	Current year COBRA rates. COBRA rates for the two prior years and the renewal rates if available.	Current Broker can assist if needed.
☐	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.
☐	Monthly claims information (minimum 2 years required) Including total enrollment numbers for subscribers and dependents.	The Third Party Administrator (TPA) if the City or Town does not have a copy on hand.
☐	Large Claimant data matching the two year claim period above, including prognosis and diagnosis information.	The Third Party Administrator (TPA) if the City or Town does not have a copy on hand.

MUNICIPAL CONTACT AND MEDICAL BENEFIT INFORMATION	
City/Town of:	
Name of Human Resource Director or Fiscal Officer responsible for insurance benefits:	
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 Reinsurance Carrier:	
Number of Years with Current TPA/Reinsurer:	

EMPLOYEE AND EMPLOYER CONTRIBUTIONS	
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/CHILD(REN): $_____	EMPLOYEE/SPOUSE: $_____ FAMILY: $_____
REINSURANCE CONTRACT TERMS		
Specific Level:		
Aggregating Specific? If so, what limits?		
Specific Monthly Premiums:	EMPLOYEE:_____ EMPLOYEE/CHILD(REN):_____	EMPLOYEE/SPOUSE: _____ FAMILY:_____
Aggregate Monthly Factors:	EMPLOYEE:_____ EMPLOYEE/CHILD(REN):_____	EMPLOYEE/SPOUSE: _____ FAMILY:_____
Current Lasers:	☐ **YES** ☐ **NO**	
Broker Fee If Known:		
Administration Monthly Fee Per Employee:		
Fully Insured Equivalent or COBRA Rates:	EMPLOYEE:_____ EMPLOYEE/CHILD(REN):_____	EMPLOYEE/SPOUSE: _____ FAMILY:_____