



## Quoting Checklist for Groups 100+ Employees Self-Funded and Fully Insured

Thank you for your interest in the Aim 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@aimmedicaltrust.org](mailto:wglista@aimmedicaltrust.org) or faxed to 765-464-6213. Wendy can be reached at 765-429-5012 if you have questions about the proposal process.

WHAT NEEDS TO BE SUBMITTED BY THE MUNICIPALITY		WHERE TO LOCATE REQUIRED ITEMS
<input type="checkbox"/>	Copy of current medical plan design(s). The Plan Summary or Summary Plan Document (SPD) is acceptable.	The Third Party Administrator (TPA) / Carrier if the City or Town does not have a copy on hand.
<input type="checkbox"/>	Current year rates/COBRA rates, rates/COBRA rates for the two prior years and the renewal rates if available.	The Third Party Administrator (TPA) / Carrier if the City or Town does not have a copy on hand.
<input type="checkbox"/>	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. <i>(If offering more than one medical plan identify plan each employee is participating in, PPO, HSA, etc.)</i>	This spreadsheet will need to be created by the Fiscal Officer or Human Resource Department's staff and electronically submitted to the Aim Medical Trust.
<input type="checkbox"/>	Monthly claims information (minimum 2 years required) Including total enrollment numbers for subscribers and dependents.	The Third Party Administrator (TPA) / Carrier if the City or Town does not have a copy on hand.
<input type="checkbox"/>	Large Claimant data matching the two year claim period above, including prognosis and diagnosis information.	The Third Party Administrator (TPA) / Carrier if the City or Town does not have a copy on hand.
<input type="checkbox"/>	Copy of TPA Contract and PBM Agreement, if available.	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 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 Reinsurance /Or Fully Insured Carrier:	
Number of Years with Current TPA/Reinsurer/Carrier:	
What is the current new hire benefit waiting period in place for the city/town? <i>Note: With the Aim Medical Trust, new hire benefits begin on date of hire.</i>	

### EMPLOYEE AND EMPLOYER CONTRIBUTIONS

Do the participant employees cost share in the medical premiums with an employee premium contribution?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how much does the city/town contribute towards the HSA on an annual basis?	EMPLOYEE: \$ _____                      EMPLOYEE/SPOUSE: \$ _____ EMPLOYEE/CHILD(REN): \$ _____      FAMILY: \$ _____

### REINSURANCE CONTRACT TERMS

Specific Level:	
Aggregating Specific? If so, what limits?	
Specific Monthly Premiums:	EMPLOYEE: _____                      EMPLOYEE/SPOUSE: _____ EMPLOYEE/CHILD(REN): _____      FAMILY: _____
Aggregate Monthly Factors:	EMPLOYEE: _____                      EMPLOYEE/SPOUSE: _____ EMPLOYEE/CHILD(REN): _____      FAMILY: _____
Current Lasers:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Broker Fee If Known:	
Administration Monthly Fee Per Employee:	
Fully Insured Equivalent or COBRA Rates:	EMPLOYEE: _____                      EMPLOYEE/SPOUSE: _____ EMPLOYEE/CHILD(REN): _____      FAMILY: _____