

# Prospective Member Quoting Checklist

Groups with 100+ Employees (Self-Funded or Fully Insured)




Thank you for your interest in the Aim Medical Trust. The Underwriters can begin working on a proposal when all checklist items are received. Requested information should be submitted to Jarrod Limbach via email at [jlimbach@aimindiana.org](mailto:jlimbach@aimindiana.org). Jarrod can be reached at 317-910-2995 should you have questions about the requested information or a proposal.

## Section 1: General Information

Municipality Name:			
Street Address:			
Zip Code:		Federal Tax ID:	
Contact Person Name:		Contact Person Title:	
Contact Person Phone:		Contact Person Email:	
Number of Full Time Employees:		Requested Effective Date:	

## Section 2: Information Checklist

<input type="checkbox"/>	Employee Census	Excel spreadsheet of all eligible employees, including retiree and COBRA participants. This will need to be completed by Fiscal Officer or Human Resources staff and submitted electronically to the Aim Medical Trust. See template as a reference or use to add your data.	 AMT Census Template.xlsx <i>(click here to open template)</i>
--------------------------	-----------------	--	---

**The following information can be provided directly from the municipality, or you may sign a release letter to allow the Aim Medical Trust and our Advisor, LHD Benefit Advisors to request the information from your insurance carrier(s). Please indicate below whether you will be providing the information or if you will be signing the release letter (see attached) to allow the Trust and its advisor to request the information from your carrier(s).**

<input type="checkbox"/>	Current SPD or Certificates of Coverage	Please provide documents for all current coverage as indicated in Section 3 (Medical, Dental, Vision, Life & Disability)	<input type="checkbox"/> Provided <input type="checkbox"/> Release Signed
<input type="checkbox"/>	COBRA/Premium Rates	Please provide current year rates, rates for two most recent years, and renewal rates, if available for all current coverage as indicated in Section 3 (Medical, Dental, Vision, Life & Disability)  <i>NOTE: carrier will likely not have COBRA rates, Municipality will need to provide if self-funded</i>	<input type="checkbox"/> Provided <input type="checkbox"/> Release Signed
<input type="checkbox"/>	Claims Data	Medical and Rx claims data for 2 years including monthly aggregate claims, subscriber and member enrollment and large claimant data including prognosis and diagnosis information for the same time period.	<input type="checkbox"/> Provided <input type="checkbox"/> Release Signed
<input type="checkbox"/>	Administrative Contracts	Copy of Medical TPA contract, Pharmacy Benefit Manager (PBM) agreement, and Stop Loss policy.	<input type="checkbox"/> Provided <input type="checkbox"/> Release Signed

*Please utilize this letter template for release of information to the Trust and its Advisor.*



# Prospective Member Quoting Checklist

Groups with 100+ Employees (Self-Funded or Fully Insured)



## Section 3: Current Coverage Information

Check the box next to each line of coverage that is currently offered to employees by your municipality and complete the requested information about each line of coverage.

<input type="checkbox"/> <b>Medical</b>				
Current Carrier/TPA:		Yrs. w/ Current Carrier/TPA:		
Number of Plans Offered:		Number of Medical Plan Employee Participants:		
Types of Plans Offered: <i>(Select all that apply)</i>	<input type="checkbox"/> PPO	<input type="checkbox"/> HDHP/HSA	<input type="checkbox"/> EPO	<input type="checkbox"/> HMO
Does your city/town contribute toward employee HSAs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much do you contribute on an annual basis?	EE \$ ES \$ EC \$ FAM \$
Do participant employees contribute toward cost of coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, approximate average % of total premium employees contribute for all plans	EE % ES % EC % FAM %
What is your new hire eligibility waiting period?				

<input type="checkbox"/> <b>Dental</b>		<input type="checkbox"/> <b>Vision</b>	
Current Carrier:		Current Carrier:	
Contributory Status:	<input type="checkbox"/> 100% employee paid <input type="checkbox"/> 100% employer paid <input type="checkbox"/> Cost Shared	Contributory Status:	<input type="checkbox"/> 100% employee paid <input type="checkbox"/> 100% employer paid <input type="checkbox"/> Cost Shared

<input type="checkbox"/> <b>Employer Paid Life/AD&amp;D</b>	
Current Carrier:	

<input type="checkbox"/> <b>Short-Term Disability</b>		<input type="checkbox"/> <b>Long-Term Disability</b>	
Current Carrier:		Current Carrier:	
Contributory Status:	<input type="checkbox"/> 100% employee paid <input type="checkbox"/> 100% employer paid <input type="checkbox"/> Cost Shared	Contributory Status:	<input type="checkbox"/> 100% employee paid <input type="checkbox"/> 100% employer paid <input type="checkbox"/> Cost Shared