PartnerRe

Employer Excess of Loss - Request for Quotation

CLIENT SPECIFIC INFORMATION

Name of Employer Group:

Principal Address:

City: State: Zip:

Domiciled State (if different):

Other Locations:

Nature of Business: Self-Insured Since:

Name of TPA: Name of Network:

CURRENT COVERAGE

Current Carrier:

Years with Current Carrier:

Policy Period
Effective Date: Expiration Date:

Specific Deductible(s): Services Covered:

Aggregate Attachment %: Services Covered:

Contract Basis: Aggregate Contract Basis:

Current Monthly Rates:	Composite	Single	Family
Specific:			
Aggregate Attachment Factor:			
Aggregate Premium Rate:			

REQUESTED COVERAGE

Due Date:

Policy Period
Effective Date: Expiration Date:

Specific Deductible(s): Services Covered:

Aggregate Attachment %: Services Covered:

Specific Contract Basis: Aggregate Contract Basis:

Other Changes from Current Policy:

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ENROLLMENT

Eligible Employees:	COBRA Single:
Participating Single:	COBRA Family:
Participating Family:	Covered Retirees Under 65:
Number of Union Employees:	Covered Retirees 65 and Over:

CLAIMS INFORMATION

For Specific Coverage provide the following information:

- Individual claimant experience in excess of 50% of the lowest specific deductible for the current and prior three years including diagnosis, prognosis and expected future costs for the next 12 months

For Aggregate Coverage provide the following information:

- Monthly claims experience for the last three years and current year

ADDITIONAL INFORMATION

- Schedule of benefits for every plan offered
- Employee census with home zip code, age, gender, plan, and coverage (single/family)
- Monthly enrollment for last three years and current year
- Claims information (three years)
- Enrollment information (three years)

BROKER OF RECORD

Broker of Record: ☐ Yes ☐ No If yes, number of years as BOR:

Date Quotation Due:

Broker Commission (expiring):

Broker Commission (requested):

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SIGNATURE

The proposal will be based upon information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.

Signature: Date:

Title:

Phone:

E-mail Address:

CONFIDENTIALITY

WARNING: This form contains personal and Protected Health Information under HIPAA and may be transmitted only in a HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**