PartnerRe

Medical Excess Reinsurance – Request For Quotation

CLIENT-SPECIFIC INFORMATION

Name of Reinsured: _____

Address: _____

State of Domicile: _____ NAIC#: _____ AM Best Rating: _____

Affiliates/Subsidiaries: _____

CURRENT COVERAGE

Current Reinsurer: _____

Agreement Term: _____ Retention: _____

Contract Basis: _____ Rates: _____

REQUESTED COVERAGE

Business Reinsured: _____

Agreement Term: _____ Retention: _____

Contract Basis: _____ Limits: _____

PORTFOLIO DETAILS

Please provide the following information on the portfolio to be reinsured:

- Historical enrollment/membership for at least two, preferably three, years
- Geographic breakdown of portfolio by state (by zip code if available)
- Age/gender distribution of the portfolio
- Distribution of portfolio by individual and family coverage
- Portfolio broken down by type of business (fully insured, self-funded, individual, group, etc.)
- Breakdown of portfolio by industry classification (if portfolio is weighted toward any specific industry)

PORTFOLIO DETAILS

Please provide the information below for individual claimants that have exceeded 50% of the specific deductible and/or have a trigger diagnosis expected to exceed the specific deductible. Please email the information below, for the last four years, in an Excel spreadsheet.

Member name	Unique ID #	Diagnosis or ICD-9	Prognosis	Primary hospital	In/Out of network	Dates of service	Total charges	Total paid

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NETWORK INFORMATION

Please provide the name of the PPO network(s) currently utilized.
Please also indicate the states in which the network is utilized.

Network	States Utilized

Attach copy of a recent network geographic match if available.

% of claims in network: _____

Network discount: _____

How are claims handled outside of network? _____

Is a transplant network currently utilized? If so, please specify:

Please check hospitals where tertiary services are rendered:

Service category	In-Network hospital	Referral hospital	If referral, provide name of hospital	If referral, provide negotiated rate
Neonates				
Level 1				
Level 2				
Level 3				
Organ transplants				
DRG 103				
DRG 302				
DRG 480				
DRG 481				
Other				
DRGs 75, 104-110				
Trauma				

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RISK ATTACHING

If risk attaching, please also include the following: Group's effective date, contract type, and annual/lifetime limit.

Incurred and paid dates should correspond to the coverage requested (i.e., 15/12, 12/24, etc.)

CASE MANAGEMENT

Describe the mechanism for identification of members who require medical management.

Describe the measures used to prevent inpatient hospitalization.

Describe the criteria for providing case management services to members.

Please provide the following contact information:

Medical management	Contact name	Phone number
Director of medical management		
Utilization review		
Case management		
Transplant network vendor		
Disease management vendor		
Subrogation vendor		

ADDITIONAL INFORMATION

Please disclose any material changes to the risk in the most recent 12 months that the underwriter should note, i.e. changes to policy benefits, PPO networks utilized, changes in composition of the portfolio, etc.

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DOCUMENTS TO ATTACH WITH THIS FORM

- Requested portfolio details on previous page
- Excess claims experience (four years)
- Corresponding enrollment information (four years)
- Network geographic match
- Underlying policy/policies
- Medical underwriting manual (if business reinsured is individual medical)
- Most recent annual financial statements
- Census (including gender, date of birth, home, zip code, coverage tier and plan and network, if more than one is utilized)

BROKER OF RECORD

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

Date Quotation Due: _____

Broker Commission (expiring): _____

Broker Commission (requested): _____

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

This document and any attachments are confidential and also may be privileged. If you are not the named recipient, or have otherwise received this document in error, please notify the sender immediately, delete the document, and do not disclose its attachments to any other person, use them for any purpose, or store or copy them in any medium. Thank you for your assistance.

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