Quartz Stop-Loss Proposal Request

This form identifies the information required to obtain a **Quartz** self-funded claims administration proposal.
In order to submit the information, complete this form and return with supporting documentation files.
If any noted information is missing from the request, we may be unable to provide a proposal.

☐ New Business ☐ Renewing Business

840 Carolina Street | Sauk City, WI 53583
(608) 644-3410 | (877) 849-1029 (toll-free)
QuartzASO.com

AGENT INFORMATION

Name of Agency: _____ Name of Agent: _____

Address of Agency: _____

Phone: _____ Email: _____

COMPANY INFORMATION

Company's Complete Legal Name: _____

Tax ID Number: _____

Address: _____

Contact Name: _____

Contact Email: _____ Contact Phone: _____

SIC Code / Nature of Business: _____

(Affiliates / Subdivisions: Include complete list with Name; Address; City; State; Zip; # of Employee's – attach to this completed form)

QUOTE DETAILS

Is the group currently self-funded? ☐ Yes ☐ No

If yes, list your current excess loss carrier as well as the two previous excess loss carriers. Include the effective dates for each carrier:

_____

_____

If no, list current insured carrier:

_____

Quote current plan design? ☐ Yes ☐ No

If no, list alternative plan options:

_____

Effective Date: _____ Commission: (*percent or flat amount*) _____

Specific Deductible Level: _____ Benefits Covered: ☐ Medical ☐ RX

Aggregate Deductible Level: _____ Benefits Covered: ☐ Medical ☐ RX ☐ Dental ☐ Vision

Contract Type: ☐ 15/12 ☐ 12/12 ☐ 12/15 ☐ Other Total Number of Eligible Employees: _____

Coverage (*Mark all that apply*): ☐ Active full-time ☐ Part-time / Seasonal ☐ Retiree ☐ Other (_____)

List class of employee not eligible for coverage: _____ Effective Date of Coverage: _____ Waiting Period: _____

Termination Date of Coverage: ☐ Immediate ☐ End of Month ☐ Other (_____)

CENSUS

(In Electronic Form Only)
Excel listing of all plan participants that includes:

- Date of Birth
- Plans Offered
- Identify Plan Elected
- Gender
- Coverage Type (i.e. single, ee / sp, ee / ch, fam)
- Relationship – Status (Active, Retiree or COBRA)
- Number of Dependents
- Zip Code

SUPPORTING DOCUMENTATION

Accompanying documentation must include the following –

- A complete description of the group's current program plus, all benefit changes for the past three years – *Include all riders, fixed dollar copays, etc. and Plan Document or Summary of Benefits and Coverage, if available*
- Plan design(s) – *If more than one plan, indicate number or percentage in each plan*
- Two to three years large claims experience – *Include paid amounts, diagnoses, treatment plans, prognoses, if available and indicator if the participant is active*
- Two to three years monthly claims and enrollment – *Include member and subscriber counts*
- Current PPO network(s) utilized
- If currently self-funded, include current and renewal rates and factors and / or copy of excess loss policy
- If currently insured, include two to three year rate history, including renewals
- Inclusions within specific and aggregate amounts