MAVERICK HEALTH

STOP LOSS REQUEST FOR PROPOSAL

Due Date [   ]   **Effective Date** [   ]

EMPLOYER INFORMATION

GROUP NAME [   ]

ADDRESS [   ]

INDUSTRY [   ]

SIC CODE [   ]   **# OF EMPLOYEES** [   ]   **# OF ENROLLEES** [   ]

CURRENT COVERAGE

Self Funded / Level Funded		Fully Insured	
CARRIER		**CURRENT CARRIER**	
TPA		**YEARS WITH INCUMBENT**	
CURRENT NETWORK		**EFFECTIVE DATE**	
EFFECTIVE DATE		**PRIOR CARRIER**	
YEARS WITH INCUMBENT		**YEARS WITH PRIOR CARRIER**	
YEARS WITH PRIOR CARRIER			

Commission in current Stop Loss rates [   ]

Include Current Rates and Proposed Renewal Rates (enrollment must be displayed for each plan and coverage tier)

* Include Current Stop Loss Application/Policy & Proposed Renewal

REQUESTED COVERAGE

PROPOSED TPA [   ]   **RETIREES COVERED**   YES   NO

PROPOSED NETWORK(S) [   ]

REQUESTED COMMISSION [   ]

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
SPECIFIC DEDUCTIBLE						
AGGREGATING SPECIFIC DEDUCTIBLE						
SPECIFIC CONTRACT BASIS						
AGGREGATE CONTRACT BASIS						
SPEC BENEFITS (MM/RX, MM ONLY)						
AGG BENEFITS (MM/RX, MM ONLY)						

OPTIONAL COVERAGE AND CARVE OUTS

SPECIFIC ADVANCE FUNDING ☐ YES ☐ NO   **Specialty Rx Vendor and Program** [   ]

SPECIFIC TLO ☐ YES ☐ NO   **Transplant Carveout** ☐ YES ☐ NO

AGG ACCOMMODATION ☐ YES ☐ NO

AGGREGATE TLO ☐ YES ☐ NO

ADDITIONAL NOTES

[   ]

RFP CHECKLIST

Census in Excel. Include DOB/Age, Sex, Coverage, Zip Code, Plan Elections, COBRA/Retiree, Waivers w/Reason

Schedule of current benefits / Proposed benefits (if applicable)

Large claimant reports that include dx (current and prior 3 years)

Monthly Claims/enrollment reports (current and prior 3 years)

Precert/CM/UR/Trigger dx reports for past 180 days

Individual applications if no experience available

Current Rates and Renewal Rates

Pend/Unpaid/Denied Report if available (required to finalize run-in contracts)