Avera Health Plans

Request for Stop Loss Quotation

Employer Information

Company Name _____ Nature of Business/SIC Code _____

Company Address _____ Eligible Employees (#) _____

Requested Effective Date _____ Enrolled Employees (#) _____

Other Locations _____

Current Information

Current Carrier _____ Fully Insured or Self-Funded _____

Current TPA _____ Current Network _____

	Current Rates	Renewal Rates
Fully Insured		
Specific Stop Loss		
Aggregate Stop Loss		

Specific Contract _____ Specific Deductible _____

Aggregate Contract _____ Aggregate Factor _____

Aggregating Specific Deductible _____ Commission Level _____

Broker/Agency _____

Carrier History _____

Requested Coverage

Specific Coverage

Deductibles _____ ($50,000)

Contract _____ (12/12, 12/15, 12/18, etc.)

Benefits _____ (Medical/Rx)

Aggregate Coverage

Risk Corridor _____ (125% or 120%)

Liability Limit _____ ($1,000,000, $2,000,000, etc.)

Contract _____ (12/12, 12/15, 12/18, etc.)

Benefits _____ (Medical/Rx)

Commission Level _____

Proposed Network _____

Optional Provisions _____

Commission Level _____

Additional Information _____