



300 N. Meridian Street, Suite 1710, Indianapolis, IN 46204
www.valenzhealth.com/stoploss Phone: 1.877.884.6475 Fax:
463.203.5151 Please submit your request for proposal to our
underwriting mailbox: stoplossproposals@valenzhealth.com

INFORMATION NECESSARY TO OBTAIN A PROPOSAL

TPA:	
Broker:	
Case Name:	
City, State, ZIP:	
Type of Business:	
SIC Code:	
Due Date:	
Effective Date:	

Census Requirements:

1. Age/Date of Birth, Zip code
2. Single/Family (if tiered rating desired, then coverage designation by the tier)
3. Male/Female
4. COBRA Participants Designated
5. Retirees Designated
6. Waivers & Reason for Waiver
7. Seasonal or Part-Time Employees that are not currently eligible but could become eligible due to the ACA guidelines effective 1/1/15

Include as much information as possible:

1. Current/Renewal Rates
2. Plan of Benefits for each Reporting Period
3. Requested Plan of Benefits
4. Current PPO
5. Requested PPO
6. Requested PBM
7. When available, Claims Experience and Individual Large Claims (including individual paid amount and diagnosis/prognosis information) should be submitted. Anyone with the potential for large claims should be included as well.
8. 3 Years of Month by Month Paid Claims Experience, Including 50% Claimant Amounts and Diagnosis/Prognosis, Pre-cert, CM Trigger, Pend/Denied/Held Claims Reports
9. Month by Month Enrollment by Tier
10. Current Level of Specific Retention if Self-Funded
11. Current/Renewal Specific Rate if Self-Funded
12. Current/Renewal Aggregate Factors if Self-Funded
13. Current/Renewal Commission