SummitRe

HMO Request for Proposal

Reinsurance Effective Date:___________

Co. Name: ____ Date: ________________________

Contact Person:____ Ofc #: ________________________

Title:____ Fax #: ________________________

Address: ____ Fed Tax ID#: _________________

City, ST, Zip: ____ Proposal Due Date:_____________

Current Reinsurer:_________________________ LOB(s):___________________________________

EXCESS LOSS COVERAGE – ***Data and Information Request***

1. **Cover Letter –** Attach a letter with reinsurance options you would like to request or consider. In addition, please note any significant changes in provider contracts that may affect your past/future experience or any special concerns (*i.e. covered services or contract limits*) you may have and want to make sure are addressed in your next reinsurance agreement.
2. **Provider Contracts –** Provide a copy of your current hospital reimbursement arrangements. A summary matrix will be acceptable if it contains the reimbursement arrangements and any outlier provisions.
3. **3 Years of Claims Detail** – By reinsurance year, by line of business, for any member whose claims exceed 75% of the lowest requested deductible. It should also include data for the covered services being requested in the reinsurance proposal (i.e. inpatient only, inpatient and outpatient, or all services). Detail should include:
   a. Line item detail for each hospital confinement
   b. Column headings: Member ID, Provider Name, Provider Type, Admit Date, Discharge Date, Length of Stay, Place of Service Code. Primary Diagnosis Code, Diagnosis Description, Billed Charges, Allowed Charges, Paid Charges.
4. **3 Years of Member Months** – Provide this information by month by line of business for the past 3 years.
5. **Financial Statements** – Provide if you are requesting continuation-of-benefits-in-the-event-of-insolvency coverage. Attach a copy of your company's latest audited financial statement, as well as the most recent statutory annual and quarterly statements. Also include the most recent actuarial statement of opinion.
6. **Copy of Current Reinsurance Agreement(s)**

I hereby certify that the information provided above is complete and accurate. I understand that in the event Zurich American Insurance issues the reinsurance coverage being requested, the agreement provisions and premium rates will be based on the information provided in this Request for Proposal and any supplementary information. If such information is later found to be incomplete or inaccurate, Zurich may, at its discretion, consider that there has been a material change and may adjust premium rates accordingly.

Completed By: ____

Title: ____

Please return the completed questionnaire to:

Summit Reinsurance Services, Inc.
7030 Pointe Inverness Way, Suite 350
Fort Wayne, IN 46804
Phone: (260) 469-3000
Fax: (260) 469-3014