ORIEN
RISK ANALYSTS

Request For Medical Stop Loss Coverage

Proposed Effective Date: _____ Date Proposal Needed: _____

Name of Client: _____

Address: _____

Nature of Business (SIC Code): _____ Current client YES / NO

Specific Deductible Requested: $_____

Contract Basis Requested: 12/12____ 12/15____ 15/12____ 24/12 ____Other_____

Specific Advance: _____ Aggregate Accommodation: _____ Terminal Liability: _____

Network: _____

Current Carrier _____

Current Enrollment: EE _____ EE+Dep _____ EE+Ch _____ Family _____

Current Rates: EE _____ EE+Dep _____ EE+Ch _____ Family _____

Current Factors: EE _____ EE+Dep _____ EE+Ch _____ Family _____

Renewal Rates: EE _____ EE+Dep _____ EE+Ch _____ Family _____

Renewal Factors: EE _____ EE+Dep _____ EE+Ch _____ Family _____

Coverages: Medical _____ Rx _____ Plan Max: _____ Commissions _____%

Attached Data: Census____ Claims Data _____ Shock Losses _____ Plan Design _____

Contact: Name_____ Phone: _____Email:_____

Comments / Options: _____

_____

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