ORIEN
RISK ANALYSTS

Request for Medical

Stop Loss Coverage Information

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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