

# PERICO LIFE INSURANCE COMPANY



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## REQUEST FOR EXCESS LOSS PROPOSAL

Date Proposal needed \_\_\_\_\_  
Effective date proposed \_\_\_\_\_

1. Legal name of applicant \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Nature of Business \_\_\_\_\_ SIC Code \_\_\_\_\_  
Does the applicant have multiple locations?  Yes or  No

3. Details of current coverage:  
a. Type of Plan:  Fully Insured  Minimum Premium  Self-Funded  
b. Carrier and /or Third Party Administrator \_\_\_\_\_  
c. Employer contributes \_\_\_\_\_% of the cost of employee coverage and \_\_\_\_\_% of dependent coverage.  
d. Attach copy of the current plan of benefit booklet or a description of the benefit schedule.  
e. Are any changes to the current plan of benefit proposed?  Yes  No  
If yes, please include a copy of the current plan and the proposed plan of benefits.  
Give brief details of the schedule of benefits in effect if different from the current schedule.  
f. Attach latest census giving details of age, sex, and dependent status.

4. Coverages Requested:  
A. SPECIFIC EXCESS LOSS INSURANCE  
a) Specific deductible amount per policy period \$ \_\_\_\_\_.  
b) Basis of coverage: Current contract \_\_\_\_\_ Requested contract \_\_\_\_\_.  
c) Coinsurance Factor (reimbursement percentage) \_\_\_\_\_% (100% unless otherwise specified).  
B. AGGREGATE EXCESS LOSS COVERAGE  
(a) Basis of coverage: \_\_\_\_\_ Current contract \_\_\_\_\_ Requested contract \_\_\_\_\_  
(b) Coinsurance Factor (reimbursement percentage) \_\_\_\_\_% (100% unless otherwise specified).  
(c) Options:  Aggregate Accommodation  Terminal Extension  
C. BENEFITS TO BE CONSIDERED FOR AGGREGATE AND SPECIFIC EXCESS RISK INSURANCE :  
(Please circle, which options you, would like to include).

Prescription Drug Card, Rx (Aggregate, Specific, or both), Dental, Vision, or Short Term Disability.

5. Proposed Third Party Administrator \_\_\_\_\_  
(If Perico does not approve administrator, any proposal issued will be on a tentative basis subject to that approval).

6. Current Enrollment:  
Covered employees \_\_\_\_\_ Eligible employees \_\_\_\_\_  
Covered dependent units \_\_\_\_\_ COBRA \_\_\_\_\_ Retired \_\_\_\_\_

7. Please provide all large claims details including amounts and diagnosis.

### 8. PRIOR EXPERIENCE SUMMARY:

For the last two-three years, please provide the information requested below, either in the space provided or on a separate sheet. IMPORTANT – Please give particular attention to the following points:

- (a) Any medical claim exceeding 50% of the requested deductible, the total amount paid (not just amounts over the specific deductible), dates incurred, diagnosis and prognosis.
- (b) Identify any first year coverage periods or periods, which do no include run-in.
- (c) If the group was self-funded, please provide paid claims and enrollment on a monthly basis (paid claims should include any amount in excess of the specific deductible).

### 9. RATES AND FACTORS

Current Rates: Fully Insured/Self-Funded

Single \_\_\_\_\_  
EE+Spouse \_\_\_\_\_  
EE+Child \_\_\_\_\_  
Family \_\_\_\_\_

Current Aggregate Factors:

Single \_\_\_\_\_  
EE+Spouse \_\_\_\_\_  
EE+Child \_\_\_\_\_  
Family \_\_\_\_\_

(Please include in submission rates for Rx, dental, and weekly indemnity if applicable.)

10. LIFE INSURANCE:

Amount: \$ \_\_\_\_\_

Dependent Coverage:

Spouse \$ \_\_\_\_\_

Child (6 months & over) \$ \_\_\_\_\_

Infant (14 days to 6 months) \$ \_\_\_\_\_

Attach latest census giving details of age, sex, dependent status, and life volume.

Provide current schedule of benefits including age reduction formula and termination schedule.

Current Carrier: \_\_\_\_\_

Current Rates: Life: \$ \_\_\_\_\_/\$1,000 AD&D: \$ \_\_\_\_\_/\$1,000

Dependent Life: \$ \_\_\_\_\_/\$1,000

Note: Unless requested otherwise, proposal will be based on current schedule of benefits. If current schedule is not provided, proposal will be based on our minimum of \$15,000 per employee, reducing 35% at age 65 and terminating at age 70.