ABS Automated Benefit Services

AUTOMATED BENEFIT SERVICES, INC.

Request for Quote

This form identifies the information required for a proposal for ABS administration of a self-funded medical plan, and/or other ancillary products. In order to submit the information, complete this form and return with supporting documentation files. *This form is unnecessary if all information is included in submission.* Submit quote request and supporting documentation to absquotes@abs-tpa.com.

If any noted information is missing from the request, we may be unable to provide a proposal.

Requesting Party

Name _____

Company _____

Telephone _____ Are You An Agent? ☐ Y ☐ N

Email (for quote delivery) _____

Are you the current agent of record for this group? ☐ Y ☐ N

Quoting Information

Company Name ljkalsdf _____

Location of entities (and subsidiaries, if applicable) _____

_____

Address _____

Zip _____ State _____

SIC Code or Nature of Business _____

Is the group currently self-funded? ☐ Y ☐ N

If so, who is the current excess loss carrier? _____

If not, who is the current insured carrier? _____

This portion is to completed only if wishing to obtain an ABS self-funded plan administration proposal.

Services to be included in the proposal (mark all desired):

☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ COBRA ☐ Retiree Coverage

☐ STD ☐ HRA ☐ FSA ☐ UM/CM ☐ Online Enrollment ☐ Cost Containment (SmartClaims)

Number of plans existing in group:

____Medical ____Dental ____Prescription ____Vision

Type(s) of medical plans in group: ____Traditional ____PPO ____HDHP

If HDHP plans exist within group, please list the PBMs with which will we need to integrate.

_____

Census

Include census document in excel format. Please make sure the census includes the following information:

- Identifier, such as an ID#
- Medical plan in which enrolled
- Date of birth
- Family status
- Gender
- Zip code

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This page is to be completed only if wishing to obtain a quote on ABS self-funded plan administration proposal

Supporting Documentation

Accompanying documentation must include the following:

- 2-3 years large claims experience *Include paid amounts, diagnoses, treatment plans, prognoses, if available*
- 2-3 years monthly claims and enrollment
- Plan design(s) *If more than one plan, indicate number or percentage in each plan*
- Current PPO network(s) utilized
- If currently self-funded, include current and renewal rates and factors and/or copy of excess loss policy
- If currently insured, include 2-3 year rate history, including renewals
- Specific deductible amounts to quote
- Inclusions within specific and aggregate amounts

Additional Information Required

- Contract basis to quote: _____/_____
- Commission requested: _____% or flat amount: _____

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This page is to be completed only if wishing to obtain a quote on additional ancillary products

Scope of Requested Proposal

Ancillary products to be included in quote. *Mark all options desired:*

_____HRA
- _____Deductible reimbursement only *-or-*
- _____Deductible and coinsurance

_____FSA
- _____With Debit Card *-or-*
- _____Without Debit Card
- _____Dependent Care

_____COBRA

_____Self-Funded Plan Administration:
- _____Dental
- _____Vision

_____Online Enrollment

Online enrollment, eligibility and billing services for medical, dental, vision, life, LTD and STD plans

Is loading of prior year eligibility and enrollment data by ABS desired? ☐ Y ☐ N

Number of carrier feeds required:_____

_____Other administration desired: _____

Supporting Documentation

For self-funded ancillary plan administration, provide the following if currently self-funded:

- 2-3 years claims experience, if available
- Plan design(s) *Current plan design and proposed difference for new contract period, if applicable*
- Current premium and administration fee(s), and renewal rates
- Number of employees to be enrolled in ancillary product for ABS administration: _____
- Is the group's medical insurance or plan administration (currently or as of the effective date of this ancillary product administration) with ABS or US Health and Life Insurance Company? ☐ Y ☐ N

Additional Information Required

- Commission requested: _____% or flat amount: _____