DICKERSON
ALTERNATIVE FUNDING
AN **ALERA GROUP** COMPANY

Group HRA • Level-Funding
Self-Funding/Benefit Captive
alternativefunding@dickerson-group.com

REQUEST FOR AN ALTERNATIVE FUNDING PROPOSAL

Proposal for (check all that apply): ☐ **Group HRA** ☐ **Level-Funding** ☐ **Self-Funding/Benefit Captive**

Date Submitted: _____ DateNeeded: _____

PART 1: BROKER INFORMATION

Producer Name: _____ Agency Name: _____

Agency Address/City/State/Zip: _____

Telephone: _____ Telefax: _____

Email Address: _____

Current Broker of Record – Yes: ☐ No: ☐ Dickerson Sales Executive: _____

PART 2: BASIC GROUP INFORMATION

Legal Name: _____

DBA Name: _____

Physical Address/City/State/Zip: _____

Mailing Address if different: _____

Key Contact Name: _____ Title: _____

Telephone: _____ Telefax: _____

Email Address: _____

Nature of Business: _____ SIC Code: _____ TaxIDNo.: _____

Proposed Effective Date: _____ Waiting Period: _____

Employer Contribution – Employees: _____ Dependents: _____

No. Eligible Employees: _____ No. Eligible Employees in CA: _____ No. COBRA Employees: _____

Retirees offered coverage? - Yes: ☐ No: ☐ Common ownership with other firms? – Yes: ☐ No: ☐

Are group health benefits currently offered: Yes: ☐ No: ☐ Health Renewal date: _____

Workers Comp Insurer: _____ Comp Renewal date: _____

If ***KAISER PERMENENTE*** is currently offered: ☐ Will remain in place ☐ Total replacement

PART 3: REQUIRED ITEMS TO QUOTE

☐ **Member Level *Census*** (includes dependent DOB, employee address, employee ID No.)

☐ **Most Recent Monthly Carrier *Billing Statement(s)***

☐ **Carrier Renewal *Statements*** (current and prior two years)

☐ ***Carrier Plan Document, Summary Plan Description*** or ***Certificate of Coverage***

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Group Name: _____

PART 4: EMPLOYER HEALTH & COVERAGE QUESTIONNAIRE

Question #1: *To your knowledge, has any covered person in the group* ***incurred health claims more than $15,000*** in the last 12 months? __**Yes** __**No.** If yes, please provide details including **date, diagnosis, prognosis**, and **dependent status** (you may attach an additional sheet of paper to this form):

_____

Question #2: Are there any ***currently disabled persons*** in the group? ☐ **Yes** ☐ **No.** If yes, please provide the number of **disabled persons** and their known **condition**(s):

_____

Question #3: Are there any catastrophic or other ***serious medical conditions, including pregnancies,*** current ***hospital confined*** or ***not-active-at-work*** persons in the group? ☐ **Yes** ☐ **No.** If yes, please provide details including the number of current pregnancies below:

_____

Question #4: Are all employees covered by ***workers' compensation*** insurance? ☐ **Yes** ☐ **No**. If no, please provide the number of employees who are **NOT** covered by workers' compensation insurance below:

_____

Question #5: Has any owner or principal filed ***bankruptcy*** within the past seven (7) years, or known to be planning to file for bankruptcy? ☐ **Yes** ☐ **No.**

_____

Question #6: Does employer currently ***reimburse employees*** for any part of their normal out-of-pocket medical costs? ☐ **Yes** ☐ **No.** If yes, please **describe arrangement** (i.e., FSA, HSA, HRA, MERP, etc.) below:

_____

PART 5: ADDITIONAL ITEMS NEEDED FOR LARGE GROUP PROPOSALS

☐ If Fully Insured or ***Self-Funded, Large/Shock Loss Claims History*** with date, diagnosis, prognosis

☐ If Fully Insured, ***Paid Premium History*** for current and prior two years

☐ If Fully Insured or Self-Funded, ***Paid Claims History*** for current and prior two years

☐ If Self-Funded, ***Aggregate Stop Loss Reports*** for current and prior two years

☐ If Self-Funded, ***Specific Stop Loss Reports*** for current and prior two years

☐ If Self-Funded, copy of current ***Administrative Services Agreement***

☐ If Self-Funded, copy of current ***Stop Loss Insurance Policy***

PLEASE SEND THIS FORM AND ATTACHMENTS TO:

Dickerson Insurance Services Alternative Funding Division • 400 Sunrise Ave., Ste. 250, Roseville, CA 95661
Phone: 1-877-361-7342 • Fax: 1-877-360-7342 • Email: alternativefunding@dickerson-group.com

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ALTERNATIVE FUNDING QUOTE REQUEST MENU

GROUP HRA CARRIERS

(High Deductible Health Plans, TPA):

- ☐ **Aetna**
- ☐ **Anthem** Blue Cross
- ☐ **BRMS**
- ☐ **Blue Shield** of California
- ☐ **California Choice**
- ☐ **Cigna+Oscar**
- ☐ **Covered California** Small Business
- ☐ **EBAM**
- ☐ **Health Net**
- ☐ **HR Services Inc.**
- ☐ **Kaiser Permanente**
- ☐ **Navia Benefits**
- ☐ **Nippon** Life
- ☐ **Sharp** Health Plan
- ☐ **Other:** _____

LEVEL-FUNDED CARRIERS:

- ☐ **Aetna** Funding Advantage
- ☐ **Anthem** Balance Funding
- ☐ **CieloStar** Level Funding
- ☐ **Cigna** Level Funding
- ☐ **Trustmark** Level-Funding
- ☐ **Other:** _____

SELF-FUNDED CARRIERS

(Includes Benefit Captives):

- ☐ **BRMS**
- ☐ **EBAM**
- ☐ **Everest** Captive
- ☐ **McEvilly** Group
- ☐ **Prodigy** Stop Loss
- ☐ **Roundstone** Captive
- ☐ **Trustmark** Insurance
- ☐ **Other:** _____

Additional Notes/Information

_____

_____

_____

_____

_____

_____

_____

_____

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Member Level Census Specifications

DEMOGRAPHIC FIELD	NECESSITY	NOTES
Relation Code	**Required**	**E, S, C drop down**
Employee SSN/Unique No.	**Required**	**Enter without dashes**
Group Name	Optional	
Dependent SSN	Optional	
Last Name	**Required**	
First Name	**Required**	
Middle Name	Optional	
Address Line 1	**Required**	**50 character maximum**
Address Line 2	If applicable	
City	**Required**	
State	**Required**	
Zip Code	**Required**	
Dependent Address	Optional	
Email Address	Optional	
Date of Birth	**Required**	**MM/DD/YYYY**
Gender	**Required**	**M or F drop down**
Marital Status	Optional	
Date of Hire	Optional	MM/DD/YYYY
Division	Optional	
Smoker	Optional	Y or N using drop down (default to N)
Medicare	Optional	Y or N using drop down (default to N)
Salary	Optional	
Effective Date	Optional	
Plan Name	Optional	
Coverage Type	**Required**	**Select using drop down options**

The above fields in blue and highlighted in green are required minimum needed