

Business Name _____

Address _____

Nature of Business _____

Contact _____ Phone _____



Benefit Solutions, Inc.

Benefit Solutions, Inc.
PO Box 385
Taylorsville, NC 28681

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SELF-FUNDED QUOTING REQUIREMENTS CHECKLIST

- A.** CURRENT CENSUS
- B.** COPY OF CURRENT PLAN with Amendments
- C.** PRE-CERT REPORT FOR LAST QUARTER
- D.** COPY OF LATEST BILLING INVOICE
- E.** COPY OF CURRENT REINSURANCE CONTRACT
- F.** LIST OF COVERED PERSONS NOT "ACTIVELY-AT WORK"
(Hospital confined, COBRA, Retired, Disabled)
- G.** COVERED PERSONS IN EXCESS OF 50% OF SPECIFIC UNDER CURRENT CONTRACT
(Include name, diagnosis, prognosis, claims paid, claims pending)
- H.** UP TO DATE CASE MANAGEMENT REPORT
(Have been in CM or are currently in CM)
- I.** LIST OF COVERED PERSONS WITH FOLLOWING CONDITION(S):
Aids, ARC, HIV Positive, Cancer, Cardiovascular Disease, Major Trauma, Severe Burns, Brain or Spinal Cord Injury, Paralysis, High Risk Pregnancy, Premature Birth, End Stage Renal Disease, Hepatitis C, Organ Transplant Candidate Amputations, Crohns/Colitis
(Include name, diagnosis, prognosis, claims paid, claims pending)
- J.** Employer Contribution: EE _____% Dependents _____%
- K.** Requested Effective Date: _____
- L.** Current PPO: _____
- M.** Experience: Rates, claims, and enrollment for most current 3 years by line of coverage
(Indicate whether claims are "paid" versus "incurred and paid")
- N.** ANCILLARY BENEFITS ---- Include description of current plan and copy of last invoice.
GROUP LIFE: STD:
DEPENDENT LIFE: LTD:
DENTAL: VISION:
VOLUNTARY LIFE: