



Ancillary Products Administration Request for Quote

This form identifies the information required to obtain an ABS ancillary products administration proposal. In order to submit the information, complete this form and return with supporting documentation files (*the 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 for this group? Y N

Quoting Information

Company Name _____

Location of entities and subsidiaries _____

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? _____

Number of plans existing in group:

_____ Medical _____ Dental _____ Prescription _____ Vision

Type(s) of medical plans in group: _____ Traditional _____ PPO _____ HDHP

If HDHP plan(s) exist within group, is there coordination of benefits with PBM(s)? Y N

If so, list PBM(s): _____

Census

Include census document in excel format

Scope of Requested Proposal

Ancillary products administration to be included in quote (mark all options desired):

_____ HRA

_____ Deductible reimbursement only -or-
_____ Deductible and coinsurance

_____ FSA

Type of FSA: _____
_____ With Debit Card -or-
_____ Without Debit Card

_____ COBRA

_____ Self-Funded Ancillary Plan Administration:

_____ Dental

_____ Vision

_____ STD

_____ 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: _____

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