



# MediMerge Health

A MediMerge Group Company

## Rate Proposal & Renewal Submission Form

To Be Completed By:            51+ Benefit-Eligible Employee Groups  
    Self-Insured Groups of Any Size

*The following checklist has been provided to ensure that the appropriate information necessary to quote your group has been incorporated into the development of your rates.*

### Section I -- General Information

Company Name:		
Contact Name:		
Contact Title:		
Contact Email:		
Contact Phone:		
Primary Offices are Headquartered in:	,	# of Empl
Second Office Location: (if any)	,	# of Empl
Third Office Location: (if any)	,	# of Empl
Employees	Total Employees:	Total Eligible:
Nature of Business	Description:	SIC Code:
When are new Employees Eligible for Benefits ?		
Employer Contribution Policy		
Current Effective Plan Date		
Proposed Effective Date (If Different)		

## Section II -- Rating Information

Over the Past Five Years, How many times have you changed carriers ?				
Carriers:				
Financial Arrangement	Self Funded:		Fully Insured:	
If Self-insured, what are your Re-insurance levels?	Aggregate:		Specific:	
Two Year Rate History and Renewal Rates	Most Recent Year		Prior Year	
	Single		Single	
	Family		Family	
Basis of Aggregate Incurred/Paid:				
Do you want MediMerge Health, Inc. to provide a reinsurance quote?	Yes:	No:		

## Section III -- Broker / Consultant Information

Name of Broker / Consultant:			- Broker	- Consultant
Company:				
Email:				
Phone:				

## Section IV - Submission of Ancillary Documentation

1. For **Fax** submission: (978) 231-0520, **ATTN: Sales Department**
2. For **Email** submission: [mmsales@medimerge.com](mailto:mmsales@medimerge.com)

Listed below is the additional information we need to provide a self-funded quote. This information can be submitted in hard-copy, faxed or email pdf-form.

- Employee census information including gender, birth date, coverage type (individual or family), and employee zip codes
- Copy of Current Plan Document
- Copy of Current Summary Plan Document
- Current Health Care Network Affiliations

- Claims Experience for Two Years with Corresponding Enrollment by Month
- Large Loss and Potential Large Loss Claims in excess of \$20,000; Diagnosis and Prognosis

When saving a file, it is important that it be saved in one or more of the following formats:

- MicroSoft Excel
- MicroSoft Access
- Tab Delimited Text
- Comma Delimited Text

Please add any additional comments below:

Clicking Submit will create a completed Adobe PDF for emailing to MM Sales and a copy for your records.