



Risk Appraisal Form

Effective Date: _____

Business Profile

Business Name: _____

Business Address: _____

Contact: _____ Phone #: _____

Email Address: _____

Other Business Locations(City, State): _____

Type of Business: _____ Yrs. Of Operation: _____

Broker/Agency: _____ Commission: _____ %

Broker Email Address: _____ Local Service Fee: \$ _____ pepm

Is this business part of a PEO or MEWA? Yes No

Is the current plan self funded or fully insured? Self-Funded Fully Insured

If self funded, who is the current plan's Stop Loss Carrier? _____

Who is TPA for the current plan? _____

How Long? _____

If less than 3 years, who were prior TPA's? _____

How Long? _____

If fully insured, who is the current plan's Carrier? _____

How long has the current plan been with this Carrier? _____

If less than 3 years, who were prior carriers? _____

How Long? _____

Has the business ever filed, or is it in the process of filing for bankruptcy? Yes No

If yes, please give protection filed for and date of filing: _____

Group Eligibility

Total number of active eligible employees: _____

Total number of active eligible employees applying for health/dental coverage: _____

Total number of Retirees: _____

Total number of COBRA participants: _____

Total number of eligible employees not applying due to spousal coverage only: _____

What probationary period is required for new employees? _____

Total number of Temporary Employees: _____

Are all new employees subject to a waiting period for preexisting conditions? Yes No

*** [Please attach all items and return to vwebb@acsbenefitservices.com](mailto:vwebb@acsbenefitservices.com) :

- 1) **This completed Risk Appraisal**
- 2) **Census – Email Excel Spreadsheet including DOB, Gender, Coverage tier, Zip code line-by-line per ee**
- 3) **Schedule of Benefits – Current and renewal changes if any**
- 4) **Claims Experience – (2yrs.) Month-by-month of claims paid incl. each month's subscriber enrollment**
- 5) **Large Claims- (2yrs) Claims over \$10,000 incl. diagnosis/prognosis/treatment notes or disclosure statement**
- 6) **Current/Renewal Rates or Contracts/ Billing Statement/ Invoice**

Renewal

Specific:

Benefits covered under Specific: _____ Specific Deductible: \$ _____
 Specific Lifetime Max: \$ _____ Contract Basis: _____
 Aggregating Specific Amount(If any): \$ _____ Split Funded Specific Amount: \$ _____
 # of Lasers(if any) and amount of each: _____
 Monthly Aggregate Cap Premium: \$ _____
 Employee Only Premium: \$ _____ Employee + Spouse Premium: \$ _____
 Employee + Child(ren) Premium: \$ _____ Employee + Family Premium: \$ _____

Aggregate:

Benefits covered under Aggregate: _____ Contract Basis: _____ Agg. Margin: _____
 Aggregate Premium: \$ _____ Max Agg. Reimbursement: \$ _____
 Single Funding Factor: \$ _____ Family Funding Factor: \$ _____
 Single Funding Factor: \$ _____ Family Funding Factor: \$ _____

If plan is currently **Fully Insured, please provide the following information:

	Employee(EE) Only	EE/Child(ren)	EE + Spouse	Family
Current Rates:	_____	_____	_____	_____
Renewal Rates:	_____	_____	_____	_____

What is the current Employer Contribution percentage to health coverage? Employee 0% Dep. 0%
 What is the current Employer Contribution percentage to dental coverage? Employee 0% Dep. 0%

Administration

Please provide your current fees and renewal fees for the following services:

	Current	Renewal
PPO Access Fee:	_____	_____
PPO Repricing Fee:	_____	_____
Precertification/UR:	_____	_____
Prescription drug card:	_____	_____
Medical Administration:	_____	_____
Dental Administration:	_____	_____
Flex Administration:	_____	_____
Short Term Disability Fee:	_____	_____
Predictive Modeling:	_____	_____
Disease Management:	_____	_____
COBRA Administration:	_____	_____
HIPAA Administration:	_____	_____
24 Hour Nurse Line:	_____	_____
Privacy Compliance	_____	_____