

**MUTUAL MED, INC**  
**4321 E 60<sup>th</sup> STREET CT**  
**DAVENPORT, IA 52807-2501**  
**(563) 344-2890 \* FAX (563) 344-2891**

**INFORMATION NEEDED FOR A 100+ GROUP or REINSURANCE PROPOSAL**

1. NAME AND ADDRESS (Include the zip code and county).
2. TYPE OF BUSINESS (Include the SIC number if known).
3. A COMPLETE CENSUS listing the date of birth, sex and whether single, family or life only coverage is desired. If there is more than one location, please breakdown the census by location and give the zip code for each location.
  - Identify any COBRA participants and show the date COBRA will terminate.
  - List the amount of LIFE/AD&D coverage desired. If scheduled, indicate the classes and list the amount of coverage for each employee. If a salary schedule, list the salaries.
4. CURRENT CARRIER and how long you have been with them. If less than three years, list the prior carrier or carriers. Please indicate your current specific deductible amount.
5. FOR THE LAST **THREE** (3) YEARS, provide the following information:
  - a) Rates for single and family coverage broken down by line of coverage (medical, dental, etc.). Rate per \$1,000 of life/AD&D coverage. Including renewal rates (on carrier letterhead).
  - b) Claim experience by coverage (medical, dental, etc.). The most recent year should have a month-by-month breakdown, including number of employees and families covered per month.
  - c) Number of life insurance claims for each year with the amount of life/AD&D benefit paid.
  - d) The average single/family coverages for each year. The most current year should list the single/family coverages by month (or, at least, quarterly).
6. LIST ANY MEDICAL CLAIM that exceeded \$10,000 during the last twelve (12) months and provide the following information:
  - a) employee or dependent and their age
  - b) dates the injury or illness began and ended
  - c) diagnosis
  - d) prognosis
  - e) status of individual
  - f) total amount of the paid claim (for each year if the claim extends over more than one plan year).
  - g) any claims over \$100,000, an Attending Physician Statement is required.
7. PROVIDE A COPY OF YOUR CURRENT PLAN OF BENEFITS and list any changes you wish to make. Current self funded, current stop loss contract terms (12/12, 12/15, 15/12 etc).
8. EMPLOYER CONTRIBUTION toward life/AD&D, single and family coverage either as a dollar amount or percentage.
9. ARE RETIREES TO BE COVERED?