



A Tradition of Excellence

Claims Administrative Services, Inc.
P. O. Box 7500 • Tyler, Texas 75711
Phone 1-800-765-2412 • Fax 903-509-1888

GROUP HEALTH PROGRAM DATA REQUEST FORM

1) Name of Employer: _____ / Industry S.I.C. Code: _____
Street Address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
County: _____ Contact: _____
Phone: _____ Fax: _____
Email: _____
Current Agent/Broker, Consultant & Phone # _____

2) Approximate Number of Employees Working 30 or more hours: _____
Do you cover part-time employees < 30 hours per week? ____ Yes ____ No
Do you cover retirees? ____ Yes ____ No

3) Total Number of Employees currently covered under your Health Plan: _____
Of those employees covered, how many have: Single Coverage _____ / Dependent/Family Coverage _____

4) Total Number of Employees covered under your Alternate Plan: (If Any) _____

5) Name of Current Carrier/TPA: _____ (How Long) Renewal Date: _____
Name of Prior Carrier/TPA: _____ (How Long?) _____
Current Medical Rates: _____ / Renewal Rates: _____
(Attach copy of current billing)
Is your plan currently; Self-Funded Fully Insured

6) Employer Contribution for Medical/Dental/Rx: (ee only) _____ For Alternate Plan: _____
Dep only if any _____

7) Underwriting Requirements: a) Completion of this Data Request Form; b) Full Census; c) 24 months claims experience; d) large claims information over \$5,000; please include diagnosis, prognosis and \$ claims paid (see attached); e) current benefits information (copy of schedule of benefits); f) if self-insured a minimum of 2 years aggregate reports or monthly insured paid claims; g) current PPO Network; h) current specific deductible (if self-funded); i) type of self-funded contract - i.e. 12/12; 12/15; paid; j) number of COBRA participants and types of coverage

8) Are you interested in receiving a quote for a pooled program? Yes No

Signature: _____ Date: _____
Employer Representative

IF YOU SHOULD HAVE ANY QUESTIONS IN COMPLETING THIS FORM, PLEASE DO NOT HESITATE TO CONTACT BOB MITCHELL AT (800) 765-2412 OR FAX 903-509-1888.

BY YOUR SIGNATURE YOU HEREBY AGREE THAT ALL MATERIAL IN THE PROPOSAL WHICH YOU WILL RECEIVE AND ALL OTHER FUTURE INFORMATION AND DOCUMENTS IN CONNECTION WITH THIS PLAN ARE PROPRIETARY AND CONFIDENTIAL. SUCH INFORMATION AND DOCUMENTS ARE ONLY TO BE USED IN THE EVALUATION OF CLAIMS ADMINISTRATIVE SERVICES, INC. CONCEPTS AND PRODUCTS. NO COPIES ARE TO BE PROVIDED TO ANY THIRD PARTIES WITHOUT THE CONSENT OF CLAIMS ADMINISTRATIVE SERVICES, INC.





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ADDITIONAL PRE-QUALIFICATION FORM
FAX TO: BOB MITCHELL

Complete the following questions to the **best of your knowledge** for eligible employees, their dependents and any COBRA participants.

Yes No In the last 5 years has anyone been treated or diagnosed as having a serious medical condition such as: (Please check all that apply)
 Cancer Substance Abuse Mental Illness
 Alzheimer's Cirrhosis/Liver Diabetes
 HIV, AIDS Kidney Disease Multiple Sclerosis
 Cardiovascular/Heart Other _____

Yes No Has anyone had claims of \$5,000 or more in the past 12 months?
 Yes No Are any employees or covered dependents currently hospital confined or been hospital confined or had surgery in the past 3 years?
 Yes No Are any employees currently pregnant? Due Date _____
 Yes No Are any employees or covered dependents currently disabled?

If the answer is "yes" to **any** of the above questions, please provide full details below.
(Attach a separate sheet if necessary)

Employee or Dependent Age	Nature of Disorder/ Diagnosis	Treatment Dates/ Amount of Claims	Treatment/Prognosis

Signature: _____ Date: _____
Employer Representative