



County Quote Data

- **Include a copy of the current benefit plan – or complete details of the plan, co-insurance conditions, deductibles, out of pocket, co-pay amounts, and coordination of benefits.**
- **Attach a copy of current group insurance census (including dates of birth) indicating which employees are on insurance coverage.**
- **Submit a copy of most recent billing statement.**
- **Include current carrier’s experience report for past 36 months *or* Group Health Statements.**

• **County Data**

County _____	County Contact: _____
Name & _____	Contact Email: _____
Address _____	County Phone: _____

• **Employee Data**

Total number of employees at County	_____
Total number of elected officials	_____
Total number of seasonal employees	_____
Total number of employees eligible for coverage	_____
Total number covered under other insurance	_____
Current eligibility requirements for coverage (# of hrs.)	_____

• **Both Spouses employed at County**

If a husband and wife are both employees, are they usually set up under two policies or are they set up as employee/spouse? _____

How is your employer contribution handled for this situation? _____

• **Insurance Benefits**

Current Insurance Company: _____

Current Plan Renewal Date: _____

Deductible Plan Year: _____

How many options are available to participants? _____

How many are enrolled in each option? _____

What is your current Deductible? _____

What is your Co-Pay? _____

What is your current Out of Pocket Maximum? _____

Does your current plan provide?

Dental: Y N Deductible: _____ Co-Pay: _____ Annual Maximum: _____

Vision: Y N Deductible: _____ Co-Pay: _____ Annual Maximum: _____

Group Life: Y N Company: _____

Disability: Y N Company: _____

Are your rates composite or tiered? _____

Number of employees in each tier that are to be covered under the plan (include COBRA under Actives):

ACTIVES				RETIREES					
Single	Two Party	Parent/Child(ren)	Family	Retiree Single	Retiree Two Party	Retiree Family	Medicare Single	Medicare Two Party	Medicare 1+1-/65*

*One participant over 65 and one under 65 yrs.

What are your monthly health premiums for the current year and two (2) prior years?

	<u>Current Yr.</u>	<u>Prior Yr. 1</u>	<u>Prior Yr. 2</u>
Single	\$ _____	\$ _____	\$ _____
Two Party	\$ _____	\$ _____	\$ _____
Parent/Child(ren)	\$ _____	\$ _____	\$ _____
Family	\$ _____	\$ _____	\$ _____
Medicare Single	\$ _____	\$ _____	\$ _____
Medicare Two Party	\$ _____	\$ _____	\$ _____

• **Claims Experience**

- Please request claims experience from your current carrier for the past 36 months broken out into 12-month periods. This request should include:
 - Total Paid Claims
 - Number of Claims over \$50,000, and
 - Total Number of Employees covered during that period.
- Please provide run-out reports if your county has changed carriers in the past three years.
- Please provide de-identified large claims information for any claims over \$10,000 for the past 6 months including:
 - Diagnostic codes and
 - Degree of recovery.

Claims information should be sent directly to:

MACoHCT
PO Box 6668
Helena, MT 59604
Attn: Owen
 or email to ovoigt@macohct.com

If claims information is NOT available please complete and submit Group Health Statements for every employee.