Request for Coalition Quotation
Instructions

- Please complete the School/Program Contact section.
- Please provide information on your eligible student population, including whether students are voluntary or hard waiver.
- For student populations under 400 insured students, $650,000 in current, in-force premium, and have an annual student rate under $2,000, experience reports are not required.
- For student populations of 400 or more insured students, over $650,000 in current, in-force premium, or have an annual student rate of $2,000 or more, please provide the following information.
- Composite Rate is available; however, the ratio of graduate students must be 25% or lower to be eligible for Composite Rate.
- In selected states, plans that cover Intercollegiate Sports may be available.

NOTE:
All data requested is for Current year to date (2018-2019) and three years prior (2015-2016, 2016-2017, 2017-2018).

- If CONSORTIUM, all data should be submitted on combined basis and also individually by school.
- Premiums received (or premium equivalent). Are they net or gross of fees?
- Claims paid (preferably **by month**) – on an Incurred basis, that is representing claims incurred during policy year and paid at any time.
- Insured counts – separate by Student and Dependents.
- Rate History of Student and dependent rates.
- Plan document or brochures for all years (need to have **detail of definitions and exclusions)**.
- Please provide a detailed list of plan changes by year.
- **Detailed Claims Report** of the utilization of In-Patient and Out-Patient facilities, and OP Physician services for all years. These general diagnostic codes should include the following categories:

    - Surgery
    - Room and Board
    - Maternity
    - Psychiatric
    - Lab and X-Ray
    - Emergency Room
    - Physical Therapy
    - Prescription Drugs
    - SHC Charges
    - Other

- Please provide large claims above $25,000 data. Can you identify which of the 'High Dollar Claimants' are ongoing (claimant in more than 1 policy year).
- Please provide PPO and Non-PPO claims and detail of deductible, coinsurance, and co-payments paid for all years.
- Provide the total claim dollars spent at the top 20 providers and top 20 facilities, with Tax ID number.
- Please provide detailed prescription drug reports with co-pays, top drugs, etc.
- Please provide a fee schedule for services the SHC bills to the insurance carrier.

Return Completed Form to:
Julie Patrick
First Risk Advisors, Inc.
67 W. Court Street
Doylestown, PA 18901
Phone: 267-880-2300; FAX 267-880-2301
Email: jpatrick@firstriskadvisors.com

FirstRisk ADVISORS

UnitedHealthcare®

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Return to:
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67 W. Court Street ~ Doylestown, PA 19801
TEL: 267.880.2300 ~ FAX: 267.880.2301
Email: jpatrick@firstriskadvisors.com

SCHOOL INFORMATION (*Required Information)			
College/University Name*:			
Proposal Due Date*:			
Requested Effective Date*:			
School Contact Name*:			
Contact Title:			
Mailing Address*:			
City/State/Zip*:			
Telephone Number:		Fax Number:	
E-mail Address:			

Eligibility and Enrollment Type (Required)				
	# Eligible	# Enrolled	Hard Waiver	Voluntary
Domestic Undergraduate Students			☐	**N/A**
Domestic Graduate Students			☐	**N/A**
International Undergraduate Students			☐	**N/A**
International Graduate Students			☐	**N/A**
Composite Student Rate Requested (Must have a graduate ratio equal to or less than 25% of total enrollment)			☐	**N/A**
Coverage for Intercollegiate Sports (where available)			☐	**N/A**
Dependents			**N/A**	☐
Total:				
Estimated total number to be insured:				
Current, in-force annual premium:		**Current, in-force annual rate (attach separate sheet if necessary):**		

Student Health Center			
Does your SHC bill the student health insurance for any charges?	☐ **Yes**	☐ **No**	If Yes, attach list of services and corresponding fee schedule.

Notes/Comments: