Diane Pickle
Executive Director

Phone: 412-562-2279

Steelworkers Health and Welfare Fund
60 Boulevard of the Allies, Suite 700
Pittsburgh, PA 15222

David McCall
Chairman

Fax: 412-562-2276

# Request for Fund Quote

**Instructions to Staff Representative:**

- Provide the information requested below.
- Request the employer complete the attached **Request for Information** form.
- All information should be returned to the Steelworkers Health & Welfare Fund.
- A minimum of two weeks is required to prepare a Fund quote.
- If you need additional assistance, contact:
  Districts 4, 9, 10, 11, 12 Marge Bibb at 412-562-2277 or mbibb@usw.org
  Districts 1, 7, 8, 13 Moriah Jamrom at 412-562-2292 or mjamrom@usw.org

Staff Representative: _____ District: _____

Company Name: _____

CBA Expiration: _____ Proposed Effective Date: _____

Reason for Quote:

- ☐ Contract expiration
- ☐ Early negotiations
- ☐ Re-Opener due to financial hardship
- ☐ First contract with newly organized group

Fund proposals duplicate existing benefit levels as closely as possible. If you are interested in making changes to the existing benefits, it is important that we know this prior to preparing our proposal. Please make sure that a description of the current benefit plans is included, as indicated in the Employer section of this form.

**Type of request (please check all that apply):**

- ☐ Medical/Prescription Drug
- ☐ Dental
- ☐ Vision
- ☐ Life Insurance/AD&D
- ☐ Short Term Disability (STD)
- ☐ Long Term Disability (LTD)

Please return this form, along with all Company information, to the Account Executive for your District:

Marge Bibb
Steelworkers Health & Welfare Fund
60 Boulevard of the Allies, Suite 700
Pittsburgh, PA 15222
mbibb@usw.org

Moriah Jamrom
Steelworkers Health & Welfare Fund
60 Boulevard of the Allies, Suite 700
Pittsburgh, PA 15222
mjamrom@usw.org

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# Request for Information

**Instructions to Employer:**

- Please complete **ALL** sections and include **ALL** required documentation.
- A minimum of two weeks is required to prepare a Fund quote once all requested information is received.
- All Fund quotes are released to the USW Staff Representative unless directed otherwise.

**A. GENERAL INFORMATION** Date of Request: _____

Company Name: _____

Company Contact Person: _____

Telephone: _____ Fax: _____ Email: _____

Company Address: _____

Location Address: _____
(If multiple locations, please include complete address for each)

Number of Eligible Active Employees: _____

Are Salaried/Non-Union Employees included in this quote request? ___Yes ___No

Are Retirees to be included in this quote? ___Yes ___No

Number of Eligible Pre-Medicare Retirees: _____

Number of Medicare Retirees: _____

**B. CENSUS INFORMATION**

Please provide, in excel format, a complete census of all eligible employees and/or retirees to be considered in the quote, including for each:

- Date of Birth
- Gender
- Level of Coverage (Single, Employee/Child, Employee/Spouse, Family, Waived etc.)
- ZIP Code
- Employee Status (Active, Retired, COBRA, etc.)
- Hourly Rate/Annual Salary
- Benefit Amount or Class of Benefit
- Union/Non-Union

**The Fund will consider a request to include non-represented/salaried employees. If non-represented/salaried employees are included in the census, please add an additional identifying indicator.**

## C. CURRENT BENEFIT DESCRIPTION

Please include a copy of the current Schedule of Benefits or Summary Plan Description for all lines of coverage requested in the quote.

## D. CURRENT RATE INFORMATION (Report for all insured groups)

1. Indicate current monthly rates for each type of coverage (including employee contributions).

| Type of Coverage | Carrier | Individual | Employee/ Child(ren) | Employee/ Spouse | Family |
|---|---|---|---|---|---|
| Medical/Rx | | | | | |
| Dental | | | | | |
| Vision | | | | | |
| Pre-Medicare Retirees | | | | | |
| Medicare Retirees | | | | | |

| Type of Coverage | Carrier | Rate |
|---|---|---|
| Life/AD&D | | |
| Short Term Disability | | |
| Long Term Disability | | |

Rate Term: From _____ (Date) To _____ (Date)

2. Employee Contributions. If employees contribute towards the cost of the coverage, please indicate the formula used to determine monthly employee cost.

   Percentage of total monthly premium: _____
   Dollar amount of month premium: _____

- **If over 200 lives, please provide three years of rate history in the above format.**
- If already an existing Highmark client, please provide the current Group Number: _____

## E. CLAIMS EXPERIENCE – MEDICAL/RX, DENTAL AND VISION

***Required for groups with 200 or more employees***

- Most recent 36 months of claims, by month, for each line of coverage.
- Most recent 36 months of matching enrollment, by month
- Large claims over $25,000

**Do NOT include member name, Social Security Number or any other identifying information that may result in this information being considered as Protected Health Information under HIPAA (the Health Insurance Portability and Accountability Act).**

## F. CLAIMS EXPERIENCE – LIFE/AD&D, SHORT TERM DISABILTY AND LONG TERM DISABILITY

1. If quote is for STD and LTD and includes 100 or more employees:
    a. Census with dates of birth, benefit class, gender and salary/hourly rate
    b. STD and LTD paid premiums and paid claims by year for at least the most recent **two years**
    c. Rate and benefit history for the same period
    d. Effective date with current carrier and carrier name
    e. STD and LTD groups with less than 100 employees can be quoted without experience data but if the experience data is available, it may help improve the quote

2. If quote is for Life/AD&D and includes 500 or more employees:
    a. Census with dates of birth, benefit class, gender and salary/hourly rate
    b. Paid premiums and paid claims by line of coverage (Life vs. AD&D vs. Dependent Life) for the most recent **three year period**
    c. Rate and benefit history for the same period
    d. Effective date with the current carrier and carrier name
    e. Life/AD&D groups with less than 500 employees can be quoted without experience data but if the experience data is available, it may help to improve the quote

**Please provide copies of the current Life/AD&D, STD and/or LTD benefits. In all circumstances a complete copy of the current policy/certificate must be submitted.**

## G. COBRA RATES

Indicate current COBRA rates for each type of coverage.

| | Medical | Dental | Vision |
|---|---|---|---|
| Single | | | |
| Employee/Child(ren) | | | |
| Employee/Spouse | | | |
| Family | | | |