FORM A: PROPOSAL
(See B10)

1. Contract Title — REQUEST FOR PROPOSAL FOR A CITY OF WINNIPEG EMPLOYEE BENEFIT PLAN PROVIDER

2. Bidder

_____
Name of Bidder

_____
Usual Business Name of Bidder as it appears on Invoice (if different from above)

_____
Street

_____
City Province Postal Code

_____
Email Address of Bidder

_____
Facsimile Number

(Mailing address if different)

_____
Street or P.O. Box

_____
City Province Postal Code

_____
GST Registration Number (if applicable)

(Choose one)

The Bidder is:

☐ a sole proprietor

☐ a partnership

☐ a corporation

carrying on business under the above name.

3. Contact Person — The Bidder hereby authorizes the following contact person to represent the Bidder for purposes of the Proposal.

_____
Contact Person Title

_____
Telephone Number Facsimile Number

4. Definitions — All capitalized terms used in the Contract shall have the meanings ascribed to them in the General Conditions.

5. Offer

The Bidder hereby offers to perform the Work in accordance with the Contract for the Price(s), in Canadian funds, set out on Form B: Prices, appended hereto.

6. Execution of Contract

The Bidder agrees to execute and return the Contract no later than seven (7) Calendar Days after receipt of the Contract, in the manner specified in C4.1.

7. Commencement of the Work

The Bidder agrees that no Work shall commence until he/she is in receipt of a notice of award from the Award Authority authorizing the commencement of the Work.

8. Contract

The Bidder agrees that the Request for Proposal in its entirety shall be deemed to be incorporated in and to form a part of this offer notwithstanding that not all parts thereof are necessarily attached to or accompany this Proposal.

9. Addenda

The Bidder certifies that the following addenda have been received and agrees that they shall be deemed to form a part of the Contract:

No. _____ Dated _____

_____ _____

_____ _____

10. Time

This offer shall be open for acceptance, binding and irrevocable for a period of ninety (90) Calendar Days following the Submission Deadline.

11. Signatures

The Bidder or the Bidder's authorized official or officials have signed this

_____ day of _____ , 20_____ .

Signature of Bidder or
Bidder's Authorized Official or Officials

_____

_____
(Print here name and official capacity of individual whose signature appears above)

_____

_____
(Print here name and official capacity of individual whose signature appears above)

FORM Q: QUESTIONNAIRE
(See B8)

REQUEST FOR PROPOSAL FOR A CITY OF WINNIPEG EMPLOYEE BENEFIT PLAN PROVIDER

1. Confirm that your quotation conforms completely to our specifications. This includes the plan design and underwriting provisions. Note, only items identified specifically as deviations will be reviewed; detailed plan designs/schedules will not be.

   Yes _____ No _____

   If not, identify all deviations in a separate section.

2. Confirm that, if appointed as the underwriter, you will provide employee booklets at no additional cost, or alternatively, you would contribute to the cost of a composite booklet.

   No cost booklets will be provided Yes _____ No _____
   Contribution to cost of composite Yes _____ No _____
   If yes, how much?

   Please indicate how much you would charge to add another carrier's wording into your booklet? Wording will be provided electronically. _____
   Are booklets available in an electronic format? Yes ____ No ____

3. Confirm that, if appointed as the underwriter, you will provide custom forms at no additional cost, or alternatively, you would contribute to the cost custom form creation.

   No cost for custom forms Yes _____ No _____
   Contribution to cost of custom forms Yes _____ No _____
   If yes, how much?

4. If not all benefits are awarded to one carrier, what combination of benefits would you underwrite and how would this affect the quoted rates/expenses. Provide revised rates if applicable.

5. Confirm your agreement to grandfather all existing amounts of Life and Optional Life Insurance without evidence of insurability being required.

6. What are your standard provisions regarding extension of coverage for vacations, leave of absence, maternity leave, temporary lay-off, strike or walkouts.

7. What is your Life gross manual rate for this group? If you are quoting below manual rate, please confirm this spread will be maintained or your recovery intentions.

8. Indicate your breakeven loss ratios for Ambulance/Hospital, Extended Health, Vision, Prescription Drugs, and Dental if underwritten on an insured basis.

9. Explain your proposed method of renewal rating for all benefits (ie % of manual, credibility etc) and, if applicable, the determination of credibility factors.

10. Confirm that your first renewal will be based on a full 12 months of experience.

    Yes _____ No _____

    If no, explain.

11. Are you prepared to guarantee premium rates, retention factors and/or pooling charges for longer than one year?

    Premium rates: Yes _____ (for _____ months) No _____

    Retention factors: Yes _____ (for _____ months) No _____

    Pooling charges: Yes _____ (for _____ months) No _____

    If yes, is there an associated charge and/or conditions that apply?

    Yes _____ No _____

    If yes, provide details.

12. Confirm that 90 days notice will be given prior to any premium rate adjustments associated with the annual renewal of the plan.

    Yes _____ No _____

    If No, # of days _____

13. Confirm you are able to provide employee data in Excel or other editable format at renewal.

14. Identify your IBNR requirements for Ambulance/Hospital, Extended Health, Vision, Prescription Drugs, and Dental if underwritten on an insured basis.

15. Identify all pooling charges included in your quoted Health rates; specify % and/or single/family rates:

    a. Travel Assistance

    b. Large Amount Pooling

    c. 1st $ Out-of-Province/Country coverage

    Charges quoted should be on a gross basis including premium tax and/or expenses.

16. Do you apply your pooling charge to total paid claims or only non-pooled claims?

17. What is the Large Amount Pooling dollar level?

    Does the Large Amount Pooling cover:

    Drugs: Yes _____ No _____

    Vision: Yes _____ No _____

    Other Health: Yes _____ No _____

18. When do you credit pooled claims (monthly, quarterly, annually, other)? If other, please specify.

19. Is the Large Amount Pooling:

    Per certificate (e.g. per employee & family): _____

    Per insured individual (e.g. per employee, per spouse, per child): _____

    Other (please specify): _____

20. Identify retention expenses charged to underwrite Ambulance/Hospital, Extended Health, Prescription Drugs, Vision and Dental on an ASO arrangement. I**dentify whether expenses are a percentage of deposits or claims.**

BENEFITS	GENERAL ADMIN	CLAIMS SETTLEMENT	PROFIT	RISK	OTHER
Ambulance/ Hospital					
Extended Health					
Prescription Drugs					
Vision					
Dental					

21. Are you agreeable to hold the current Optional Life rates?

Yes _____ No _____

If no, explain.

22. Identify all applicable interest charges and when they apply.

23. Confirm your ability and technical requirements for electronic employee data transfer and/or claims history transfer.

24. Please identify the location(s) of the servicing office(s) and claims office(s) which would be responsible for the account.

25. Indicate which of the following services/information are available for the employee/plan administrator/consultant via your secure website.

SERVICE/INFORMATION	EMPLOYEE		PLAN ADMIN		PRODUCER	
	YES	NO	YES	NO	YES	NO
Enrolment in the plan						
Monthly billing production						
Experience reports (including drug utilization)						
Update personal information (name, address, telephone number, etc.)						
Claim status						
Print forms (claims, enrolment, etc.)						
Submit forms electronically						

Also please include information, including release dates, pertaining to future online capabilities.

26. Confirm if Employees are able to electronically submit online all Health and Dental claims.

Yes _____ No _____

If no, explain.

27. Confirm if you have online adjudication where claims submitted online are automatically processed.

Yes _____ No _____

If no, explain.

28. Confirm if Employees are able to electronically submit online all Health and Dental claims when you are second payor; i.e. once claim has been processed/reimbursed by first payor for spousal and dependent children claims.

29. Would your company be prepared to offer a Performance Guarantee related to agreed upon service standards and involving financial repercussions if not met? Please provide details.

30. Please identify/define your pre-existing provision on your Emergency Travel Health plan. Also specify the number of days and your definition of stability required before departure date if any

31. The Bidder shall indicate their preferred method of billing and payment.

_____

Name of Bidder