WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

Health and Vision Insurance Proposal Checklist

Group Name:	Effective Date:	
Address:		
City:	State:	Zip code:
Broker Name:	Agency Name:	
Broker Current Commission:	County:	
WEA Trust Sales Representative:		

Number of **TOTAL** Employees:_____
Number of **Eligible** Employees:_____
Number of **Active** Employees_____
Number of **Retirees**_____

Products to Quote:

☐ Health Current Funding Arrangement: ☐ Fully Insured ☐ Self-Funded
Deductible Credit Report: ☐ Yes ☐ No
HRA/HSA: ☐ Yes ☐ No Amount $_____
HRA Vendor Name:_____

☐ Vision ☐ Employer Sponsored ☐ Voluntary

Information required for quoting:	✓
Complete Census (Age, Gender, Zip Code, Coverage Type)—**Preferred Format is Excel**	
Current Benefit Description	
Current Rates (If ASO, need breakdown of ASO fees)	
Renewal Information (Rates, Projection)	
WEA Trust Health Questionnaire (IC OGC 4102-xxxx)	
Wage and Tax Form (UC-101) Required for groups with less than 100 enrolled employees.	
Waiver of Premium: Submit list of employees currently on waiver of premium	
Groups with 100 or more employees, include below in addition to information listed above:	✓
Claims Experience History (2 years of monthly history)	
High Cost Claims >$25,000 History (Diagnosis, and Prognosis)	
Provider Listing: List of top providers by total charges.	
Enrollment History (2 years of monthly history)	
Benefit History	
Rate History	
Carrier History	
Proposed Benefit Description/Plan Design	
Most Recent Current Carrier Bill	
Comments/Strategy/Special Notes:	