**Attachment 2, RFP # 25-509**

**Proposal Services and Benefits Worksheet**

Lake County Board of County Commissioners

Group Term Life and Accidental Death & Dismemberment (AD&D) and Short-Term Disability (STD) and Long-Term Disability (LTD) RFP

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**Effective October 1, 2025**

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| **I. General Information** |
| Proposer / Contractor Name: |  |
| Address: |  |
| Contractor Contact: |  |
| Contact email: |  |
| Telephone: |  |
| Account Manager |  |
| **Indicate the Components of the RFP your Company is proposing on:** |
| Group Term Life Insurance, AD&D  |  |
| Group STD & LTD Insurance  |  |

| **II. Scope of Services – General** |
| --- |
| **Service** | **Included in Proposal?** | **Additional Fee / Comments** |
| **Yes** | **No** |
| 1. Provide separate billing formats for each agency.
 |  |  |  |
| 1. Provide a secure on-line administration portal, to each participating agency, with limited access to information relating only to that agency to view claims status, eligibility status and be able to run reports.
 |  |  |  |
| 1. Match and administer the County’s current class descriptions, eligibility and waiting period definitions.
 |  |  |  |
| 1. Provide claim forms in web-based, paper, and PDF formats.
 |  |  |  |
| 1. Provide customer services and staffing through an experienced and dedicated team.
 |  |  |  |
| 1. Provide a dedicated Account Manager with the authority, capability and availability.
 |  |  |  |
| 1. Assist the County in developing enrollment, general marketing and informational materials.
 |  |  |  |
| 1. Incur all cost of producing, printing and mailing / distributing marketing and administrative supplies, including Certificates of Coverage.
 |  |  |  |
| 1. Provide representatives at annual enrollment benefit fairs and enrollment meetings (typically 4 onsite sessions are held). Meetings can be held virtually at the County’s discretion.
 |  |  |  |
| 1. Provide medical underwriting services with decisions on evidence of insurability made prior to effective date of initial payroll deductions.
 |  |  |  |
| 1. Provide reports as outlined on the RFP. Provide sample reports under Tab 2.
 |  |  |  |
| 1. Provide performance standards and guarantees.
 |  |  |  |
| 1. Provide a plan implementation team.
 |  |  |  |
| 1. Provide premium billing and collection from disabled members up to the waiver of premium acceptance.
 |  |  |  |

| **III. Administrative Questions** |
| --- |
| **Question** | **Response** |
| 1. Account Manager with authority, capability and availability to meet the County’s needs, that will be assigned.
 | Name |  |
| Years with Company  |  |
| # of current clients |  |
| 1. Indicate location of local service and administration office, and hours of operation.
 |  |
| 1. Indicate location of claims office, including hours of operation and toll-free phone number.
 |  |
| 1. Provide your company’s claim office administrative performance standards utilized in 2023 for the following:
	1. Average speed of answer
	2. Call abandonment rate
	3. Claim turnaround time
 | a. |
| b. |
| c. |
| 1. Indicate your company’s current AM Best financial strength rating and Financial Size Category
 |  |
| 1. Has your AM Best rating changed within the last three (3) years? If so, provide the previous rating and outline reasons for the change.
 |  |
| 1. How long has your company been administering Life and Disability insurance in Florida?
 |  |
| 1. Do you subcontract any life or disability management services to other vendors? If so, specify the roles and responsibilities of all parties included in your proposal.
 |  |

| **IV. Group Term Life / AD&D Questions** |
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| **Question** | **Response** |
| 1. Briefly describe the process and timeline for reviewing and approving waivers of premium.
 |   |
| 1. Indicate how your ported charges will impact the active employee plan experience.
 |  |
| 1. If an employee is called to active duty, will you allow spouse and child life to be continued?
 |  |
| 1. What are the life insurance options for payment to a beneficiary?
 |  |
| 1. List the exclusions and limitations to your Life Insurance plan that differ from the current plan.
 |  |
| 1. List the exclusions and limitations to your AD&D plan that differ from the current plan.
 |  |
| 1. What is your turnaround time in making a final determination on Evidence of Insurability applications and what do employees being denied coverage receive?
 |  |
| 1. Describe your appeal process for denial of benefits.
 |  |
| 1. Is your program a participating or non-participating contract?
 |  |
| 1. Provide the rate calculation formula that will be utilized in determining renewal rates beyond the guarantee period and indicate your tolerable loss ratio to be used in future renewal calculations.
 |  |
| 1. Indicate the percentage of the original life face amount that will be charged to experience for waiver claims.
 |  |
| 1. Indicate your conversion charges to the plan’s experience.
 |  |
| 1. Describe how active claim reserves are set, including interest assumptions and expense assumptions.
 |  |
| 1. What are the advantages of your Life / AD&D plan compared to other carriers?
 |  |
| 1. Describe your underwriting process and your process for appeal.
 |  |
| 1. Confirm your ability to accept electronic beneficiary information and electronic signature?
 |  |

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| **V. Group Term Life**  |  |  |
| **Benefit** | **Requested** | **Proposed** |
| **Basic Life Insurance** |  |  |
| Schedule of Benefits  | One times (1x) Annual Earnings, rounded to the next $1,000 |  |
| Plan Maximum | $200,000 |  |
| Age Reductions | Reduces to 65% at age 65-69; further reduces to 50% at age 70 and overReduction will go into effect the beginning of the plan year following the age increase. |  |
| Salary increases or decreases  | Insurance premium increases or decreases because of a change in salary or class will take effect on the October 1st following the date of change if Actively at Work. Insurance benefit pays based on salary at time of claim.  |  |
| Accelerated Death Benefit1. Benefit
2. Qualifying Event
 | a. $3,000 minimum, 80% of benefit; max of $500,000b. 12 months or less |  |
| Waiver of Premiuma. Qualifying age b. Elimination periodc. Age waiver terminates | a. under 60 b. 6 months Elimination Period c. Terminates the earlier of recover, normal retirement age  |  |
| **Additional Life Insurance** | **Requested** | **Proposed** |
| Schedule of Benefits | Increments of $10,000 |  |
| Plan Maximum | Lesser of 5xs annual earnings or $300,000 |  |
| Guarantee Issue Amount | $100,000  |  |
| Accelerated Death Benefit1. Benefit
2. Qualifying Event
 | a. $3,000 minimum, 80% of benefit; max of $500,000b. 12 months or less |  |
| Waiver of Premiuma. Qualifying age b. Elimination periodc. Age waiver terminates | a. under 60 b. 6 months Elimination Period c. Terminates the earlier of recovery, normal retirement age  |  |
| **Spouse Life Insurance** | **Requested** | **Proposed** |
| Schedule of Benefits | Increments of $5,000 |  |
| Plan Maximum  | Lesser of $150,000 or 50% of the employees elected basic and supplemental insurance combined |  |
| Guarantee Issue Amount | $25,000 |  |
| Accelerated Death Benefit1. Benefit

Qualifying Event | a. $3,000 minimum, 80% of benefit; max of $500,000b. 12 months or less |  |
| Waiver of Premiuma. Qualifying age b. Elimination periodc. Age waiver terminates | a. under 60 b. 6 months Elimination Period c. Terminates the earlier of recovery, normal retirement age  |  |
| **Dependent Child(ren) Life Insurance** | **Requested** | **Proposed** |
| Schedule of Benefits | Six months or older: $2,500, $5,000, $7,500 or $10,000 not to exceed 50% of basic and supplemental15 days to six months: $250 |  |

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| **Group Term Life Benefit Provisions** |
| Benefit Provision | Included in Basic Life | Included in Additional Life | Comments or Deviations |
| Employee | Spouse & Child(ren) |
| Yes | No | Yes | No | Yes | No |
| Waiver of Premium |  |  |  |  |  |  |  |
| Accelerated Death Benefit |  |  |  |  |  |  |  |
| Suicide Exclusion |  |  |  |  |  |  |  |
| Conversion |  |  |  |  |  |  |  |
| Portability |  |  |  |  |  |  |  |
| Survivor Financial Counseling |  |  |  |  |  |  |  |
| World Wide Travel Assistance |  |  |  |  |  |  |  |
| Repatriation Benefits |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

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| **Group AD&D Benefits** |  |  |
| **Benefit** | **Requested** | **Proposed** |
| **Basic AD&D** |  |  |
| Schedule of Benefits  | An amount equal to the amount of basic life insurance |  |
| **Additional Employee AD&D** |  |  |
| Schedule of Benefits  | Increments of $10,000 subject to the lesser of 5x annual earnings or $300,000 maximum |  |
| **Spouse AD&D** |  |  |
| Schedule of Benefits  | Increments of $5,000 not to exceed 50% of the employees elected basic and supplemental combined or $150,000Terms at age 70 |  |
| **Child AD&D** |  |  |
| Schedule of Benefits | $2,500, $5,000, $7,500 or $10,000 subject to a maximum of 50% of the employees elected basic and supplemental insurance combined |  |

| **Group AD&D Benefit Provisions** |
| --- |
| Benefit Provision | Included in Basic AD&D | Included in Additional AD&D | Comments / Deviations |
| Employee | Spouse  |
| Yes | No | Yes | No | Yes | No |
| Suicide Exclusion |  |  |  |  |  |  |  |
| Conversion |  |  |  |  |  |  |  |
| Portability |  |  |  |  |  |  |  |
| Seat Belt Benefits |  |  |  |  |  |  |  |
| Air Bag Benefits |  |  |  |  |  |  |  |
| Child Care Benefits |  |  |  |  |  |  |  |
| Higher Education Benefits |  |  |  |  |  |  |  |
| Spouse Career Adjustment Benefits |  |  |  |  |  |  |  |
| Common Carrier Benefits |  |  |  |  |  |  |  |
| Paraplegic Benefits |  |  |  |  |  |  |  |
| Quadriplegic Benefits |  |  |  |  |  |  |  |
| Exposure and Disappearance Benefits |  |  |  |  |  |  |  |
| Repatriation Benefits |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**List All Deviations to Current Group Term Life and AD&D.**

**Note:** Current certificate and any pertinent amendments are included as attachments to this Request for Proposal, and proposers are expected to perform a comparison between current plan design and proposed plan. All deviations must be disclosed, or it is assumed that you will match or enhance current benefits.

| **Group Term Life / AD&D Benefit Provisions** |
| --- |
| Benefit Provision | Deviations from Current Life / AD&D Certificate & Amendments |
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| **VI. Disability Questions** |
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| **Question** | **Response** |
| 1. Are the following methods of claims reporting available to covered employees: electronic claim, paper claim, facsimile, telephonic, and online reporting?
 |  |
| 1. What information do you require from the claimant to approve a disability claim?
 |  |
| 1. What information do you require from the County to process a disability claim?
 |  |
| 1. How does your company obtain a release of medical information from claimants and how do you follow up getting the medical information?
 |  |
| 1. What additional information do you require to approve a long-term disability claim for a participant who was approved and exhausted the short term disability benefit?
 |  |
| 1. Indicate your benefit check payment run cycle (i.e., when benefit checks are run and mailed.)
 |  |
| 1. Describe your case management process and provide outcome data, including ROI.
 |  |
| 1. Provide your Social Security approval percentage when assisting participants who apply.
 |  |
| 1. How do you handle reimbursement of overpayments following Social Security approval?
 |  |
| 1. What procedures do you use to detect fraudulent claims?
 |  |
| 1. What is your average turnaround time for making a disability claim determination?
 |  |
| 1. Indicate how disability claim denials are communicated to the employee.
 |  |
| 1. Indicate how disability claim denials are communicated to the County.
 |  |
| 1. Describe the actions your company takes to focus the disabled employee on eventually returning to work.
 |  |
| 1. Describe your process for identifying and managing rehabilitation cases.
 |  |
| 1. Is participation in your rehabilitation program mandatory or voluntary?
 |  |
| 1. Do you have an in-house rehabilitation staff dedicated solely to disability claimants?
 |  |
| 1. Describe your appeal process for denial of benefits.
 |  |
| 1. Are your company’s clinical and length of absence protocols available on-line?
 |  |
| 1. Describe your underwriting process and your process for appeal.
 |  |
| 1. Describe your process for settling LTD claims.
 |  |
| 1. Does your proposal include zero days residual?
 |  |
| 1. Indicate your residual/partial benefit calculation formula and if your plan offers a return-to-work incentive provision, please describe and provide the benefit calculation formula.
 |  |
| 1. Please describe programs, if any, you have in place to assistant an employee in returning to work.
 |  |
| 1. Please describe programs, if any, you have in place to prevent an employee from going out on a leave.
 |  |
| 1. Indicate the duration of benefits, i.e., ADEA, Social Security Normal Retirement Age (SSNRA), other.
 |  |
| 1. Indicate how trial workdays are calculated.
 |  |
| 1. Does your program include self-reported contract language? If so, please define.
 |  |
| 1. What additional provisions will your company include in your proposal to assist the County in managing disability claims?
 |  |
| 1. Is your proposed program a participating or non-participating contract?
 |  |
| 1. Provide the rate calculation formula that will be utilized in determining renewal rates beyond the guarantee period and indicate your tolerable loss ratio to be used in future renewal calculations.
 |  |
| 1. Describe how open claim reserves are set, including interest assumptions, recovery/death assumption, and expense assumptions.
 |  |
| 1. What are the advantages of your disability plan compared to other carriers?
 |  |

| **VII. Long Term Disability Benefits & Provisions** |
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| **Benefits** | **Requested** | **Proposed** |
| Benefit Percentage | 60% monthly earnings |  |
| Maximum Monthly Benefit | $5,000, less any other income |  |
| Elimination Period | 180 Days for Core Plan90 Days for Voluntary Buy-Down Plan |  |
| Benefit Duration | Social Security Normal Retirement Age or maximum benefit period provided in Summary of Benefits |  |
| Minimum Benefit | $100 |  |
| Social Security Offset | Primary and Family |  |
| Pre-Existing Condition | 3 / 12 |  |
| Mental / Nervous Limits | 24 Months |  |
| Substance Abuse Limits | 24 Months |  |
| Self-Reported or Limited Conditions Language | Not Included |  |
| Mandatory Rehabilitation | Yes |  |
| Survivor Benefits | 3xs Monthly Benefit |  |
| Waiver of Premium | Included |  |

**List All Deviations to Current LTD Plan**

**Note:** Current certificate and any pertinent amendments are included as attachments to this Request for Proposal, and proposers are expected to perform a comparison between current plan design and proposed plan. All deviations must be disclosed, or it is assumed that you will match or enhance current benefits.

| **Group Long Term Disability** |
| --- |
| LTD Benefit Provision | Deviations from Current LTD Certificate & Amendments |
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| **VIII. Short Term Disability Benefits & Provisions** |
| **Benefits** | **Requested** | **Proposed** |
| Benefit Percentage  | 60% |  |
| Weekly Benefit Maximum | $1,000  |  |
| Elimination Period (Accident/Sickness) | Injury- No eliminationIllness -7 calendar days |  |
| First Day Hospital Benefit (new for 10/1/25) | Requested  |  |
| Benefit Duration | Up to 13 weeks  |  |
| Minimum Weekly Benefit | $25 |  |
| Pre-existing Condition | 3 / 6 |  |
| FMLA | Included |  |
| Recurrent Disability | Included no elimination period |  |
| Survivor Benefit | Lesser of weekly benefit for max period or 13 weeksReduced by benefits already paid |  |

**List All Deviations to Current STD Plan**

**Note:** Current certificate and any pertinent amendments are included as attachments to this Request for Proposal, and proposers are expected to perform a comparison between current plan design and proposed plan. All deviations must be disclosed, or it is assumed that you will match or enhance current benefits.

| **Group Short Term Disability** |
| --- |
| **STD Benefit Provision** | **Deviations from Current STD Certificate & Amendments** |
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**I authorize that the responses herein are accurate.**

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**Name of Firm (Proposer)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name/Title**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**