

City of West Allis Matter Summary

7525 W. Greenfield Ave. West Allis, WI 53214

R-2003-0223 Resolution In Committee

Resolution authorizing staff to submit the Revised Stop Loss Application for the City's 2003-2004 Self-Funded PPO Medical Plan Renewal.

Introduced: 8/5/2003 Controlling Body: Administration & Finance Committee

COMMITTEE	RECOMM	ENDATION_	Approv Al	- adi	pt		
ACTION DATE: SIGNATURE O	MOVER	SECONDER	Barczak Czaplewski Kopplin Lajsic Narlock Reinke Sengstock Trudell Vitale Weigel TOTAL	AYE V V R)	NO	PRESENT	EXCUSED
Common co	UNCIL AC	Vice-	Chair .		Memb	er	
ACTION DATE: 8-5-03	MOVER	V	Barczak Czaplewski Kopplin Lajsic Narlock Reinke Sengstock Trudell Vitale Weigel	AYE	NO	PRESENT	EXCUSED

CC: admin, purund COMMITTEES OF THE WEST ALLIS COMMON COUNCIL 2003

ADMINISTRATION AND FINANCE

Chair: Alderperson Czaplewski V.C.: Alderperson Kopplin Alderpersons: Barczak

Lajsic Reinke

ADVISORY

Chair: Alderperson Reinke V.C.: Alderperson Vitale Alderpersons: Kopplin Lajsic

Narlock

LICENSE AND HEALTH

. . . .

Chair: Alderperson Barczak V.C.: Alderperson Sengstock Alderpersons: Kopplin

Trudell Vitale

SAFETY AND DEVELOPMENT

Chair: Alderperson Lajsic V.C.: Alderperson Weigel Alderpersons: Czaplewski Narlock Reinke

PUBLIC WORKS

Chair: Alderperson Narlock V.C.: Alderperson Trudell Alderpersons: Sengstock Weigel Vitale



City of West Allis

7525 W. Greenfield Ave. West Allis, WI 53214

Resolution

File Number: R-2003-0223 Final Action: 08-05-03

Resolution authorizing staff to submit the Revised Stop Loss Application for the City's 2003-2004 Self-Funded PPO Medical Plan Renewal.

WHEREAS, it is necessary to have stop loss coverage for the City of West Allis 2003-2004 Self-Funded PPO Medical Plan Renewal; and,

WHEREAS, an application is required by Humana to renew such stop loss coverage.

NOW, THEREFORE, BE IT RESOLVED by the Common Council of the City of West Allis that City staff is hereby authorized to submit the Revised Stop Loss Application for the City's 2003-2004 Self-Funded PPO Medical Plan Renewal.

BE IT FURTHER RESOLVED by the Common Council of the City of West Allis that the proper City Officials are authorized and directed to execute all related stop loss agreements on behalf of the City when provided to it by Humana for the 2003-2004 Self-Funded PPO Medical Plan Renewal.

ADM\ORDRES\ADMR233

ADOPTED

Paul M. Ziehler, CAO, Clerk/Treasurer

APPROVED

Jeannette Bell, Mayor

RECEIVED

JUN 1 3 2003

CITY OF WEST ALLIS
PERSONNEL/CIVIL SERVICE

HUMANA INSURANCE COMPANY APPLICATION FOR GROUP STOP LOSS INSURANCE ALL TERMS ARE DEFINED IN THE SPECIMEN POLICY

The statements and information provided in this Application will be relied upon and form the basis of any Policy of Insurance issued to the Proposed Policyholder. Statements and descriptions in the Application shall be deemed to be representations and not warranties. No Stop Loss coverage will be in place until the Application has been signed by the Proposed Policyholder and accepted by the Company and the Company has received the initial premium payment.

1.	Proposed Police	77	ty of West A 0 South 70 ^t est Allis, W	h Street		
	Employee Ben	efit Plan Na	me: SelfFu	anded PPO Medica	ıl Plan	
2.	Indicate Affilia	ates/Subsidia ny.	ries or othe	r related entities to	be included in this	
Name	Location	Relati	onship	Business	# of Employees	
1	lone					
3.	Does the reque	sted Group S	top-loss Po olan?	licy applied for rep	place similar group stop-	loss
	X No		Yes			
	Current coverage Prior Carrier	ge is with Hu	ımana	Term	ination Date	

None			•		Identify any class(es) of employees of the proposed Policyholder to be excluded from coverage under this Policy.						
Identify any class(es) of employees of the proposed Policyholder to be excluded from coverage under this Policy. None											
Is any hospit	personal con	n to be cove fined as of t	red under t he requeste	he Policy d effectiv	ıolder's Plaı e date?	n known to	be disabled or				
	Q	Yes		No			·				
If yes,	provi	de their nam	ies, nature (of disabili	tv and estim	ated duratio	on of the disabilit				
Under claims	writing 	g is aware o	f disabilitie	s and/or l	arge						
RAGE											
f Aggr s = inc	egate a	and Individı and paid ind	ıal Stop Lo: lividual stoj	ss must co p loss).	oincide (e.g.,	, incurred ar	nd paid aggregate				
Aggregate Group Stop-loss Coverage											
Aggreg											
	Paid o	ption									
1	Is any hospital liftyes, Underwork claims.	Is any person hospital con If yes, providual descriptions and the second secon	Is any person to be cove hospital confined as of to Yes If yes, provide their name Underwriting is aware or claims. RAGE f Aggregate and Individual in the second control of the coverage o	Is any person to be covered under the hospital confined as of the requested. Yes If yes, provide their names, nature of disabilities claims. Claims. RAGE f Aggregate and Individual Stop Logs = incurred and paid individual stop	Is any person to be covered under the Policyh hospital confined as of the requested effective. Yes No If yes, provide their names, nature of disability. Underwriting is aware of disabilities and/or lactaims. RAGE f Aggregate and Individual Stop Loss must consider a second and paid individual stop loss).	Is any person to be covered under the Policyholder's Plan hospital confined as of the requested effective date? Yes No If yes, provide their names, nature of disability and estime Underwriting is aware of disabilities and/or large claims. RAGE f Aggregate and Individual Stop Loss must coincide (e.g., as = incurred and paid individual stop loss).	Is any person to be covered under the Policyholder's Plan known to hospital confined as of the requested effective date? Yes No If yes, provide their names, nature of disability and estimated duratic Underwriting is aware of disabilities and/or large claims. RAGE f Aggregate and Individual Stop Loss must coincide (e.g., incurred as a incurred and paid individual stop loss).				

	u	incurred and paid option)						
		Monthly Aggregate Advance Option						
		Deficit Recovery Option						
		Run In. Applicant requests the Company apply all Eligible Expenses Incurred during the selected period preceding the Effective Date of the Policy to the Aggregate Stop Loss coverage.						
		☐ 90 days ☐ 120days ☐ 180 days						
	a.	Covered Unit: X Employee Semployee and Spouse Employee and Child X Family Number of Employees 344						
	b.	Covered Benefits: Medical Prescription Drug						
	c.	Minimum Annual Aggregate Deductible shall be determined by the following schedule:						
	less tha	MINIMUM ANNUAL AGGREGATE DEDUCTIBLE nan 250 but						
	d.	Annual Aggregate Group Stop Loss Amount \$ N/A						
	e.	Annual Aggregate Maximum Coverage \$N/A						
8.	Termin	al Liability Coverage (complete only if purchasing the terminal liability option.)						
	a.	Covered Unit: Employee Employee and Spouse Number of Employees Employees						
For use	in IL, 2	AZ, IN, TX, WI, KS, MO						

			Employee and Child Family		
	b.	Cover	red Benefits: Medical Prescription Drug		
	c.	Term	inal Liability aggregate attachn	nent point \$	
9.	Individ	dual Gr	coup Stop Loss Coverage		
	a.	Cover X \(\bullet\) X	red Unit: Employee Employee and Spouse Employee and Child Family	Number of Employee 344 749	S
	b.	Cover	red Benefits: Medical Prescription Drug		•
	c. d. e.	Covered Covered X E: X F: Covered N F: Annual I	al Individual Attachment/Dedu dual Lifetime Maximum al Individual Maximum Covera		\$175,000 \$5,000,000 \$N/A

CONDITIONS OF APPLICATION

It is agreed that the Policy applied for shall not become effective until the Application is approved and accepted in writing by the Company. It is further agreed this Application is the basis for the Policy applied for and that this Application shall become a part of any Policy issued by the Company.

The Applicant understands that no agent, broker or consultant has the authority to change the Policy applied for herein or to waive any of its provisions; no change in the Policy applied for herein shall be valid unless approved by an executive officer of the Company and such approval is endorsed and attached to the Policy applied for herein.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, FILES A CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION COULD BE CHARGABLE WITH A FELONY.

Dated:	Dated at:
By:	Witness:
Approved by the Company to be effective or	n
Ву:	
(Name)	(Title)

RECEIVEL

JUN 1 3 2003

CITY OF WEST ALLIS
PERSONNEL/CIVIL SERVICE

HUMANA INSURANCE COMPANY APPLICATION FOR GROUP STOP LOSS INSURANCE ALL TERMS ARE DEFINED IN THE SPECIMEN POLICY

The statements and information provided in this Application will be relied upon and form the basis of any Policy of Insurance issued to the Proposed Policyholder. Statements and descriptions in the Application shall be deemed to be representations and not warranties. No Stop Loss coverage will be in place until the Application has been signed by the Proposed Policyholder and accepted by the Company and the Company has received the initial premium payment.

1.	Proj	osed Policyho	77	ty of West A 70 South 70 th 'est Allis, W	Street			
	Emp	oloyee Benefit	Plan Na	me: Self Fu	nded PPO Med	dical Plan		
2.	Indic	cate Affiliates, rance, if any.	/Subsidia	ries or other	related entitie	s to be incl	uded in this	
Name		Location	Relati	ionship	Business	# of E	mployees	
	lone							
3.	Does	the requested	Group S	Stop-loss Pol plan?	icy applied for	replace sin	nilar group st	op-loss
	X	No		Yes				
	Curre Prior	ent coverage is Carrier	with Hu	ımana	Te	ermination	Date	

4.	Identify any class(es) of employees of the proposed Policyholder to be excluded from coverage under this Policy.							
	None	e						
5.	Ident	Identify any individual employee/dependent of the Proposed Policyholder whose coverage is to differ from the coverage applied to all other employees.						
	None	e						
	-							
6.	Is any	y person to be covered under the Policyholder's Plan known to be disabled or ital confined as of the requested effective date?						
		☐ Yes ☐ No						
	If yes	s, provide their names, nature of disability and estimated duration of the disability:						
•	Underwriting is aware of disabilities and/or large claims.							
COV	ERAGI	E.						
Types top I	of Agg oss = in	gregate and Individual Stop Loss must coincide (e.g., incurred and paid aggregate curred and paid individual stop loss).						
	Aggre	egate Group Stop-loss Coverage						
	9	Paid option						
	☑ during	Incurred and paid option (claims incurred during the Policy Year which are paid the selected period following the end of the Policy Year). 12/15 12/18 12/24						

Terminal Liability Option (only available when selecting the incurred and paid option)								
		Monthly Aggregate Advance Option						
		Deficit Recovery Option						
		Run In. Applicant requests the Company apply all Eligible Expenses Incurred during the selected period preceding the Effective Date of the Policy to the Aggregate Stop Loss coverage.						
		□ 90 days □ 120days □ 180 days						
	a.	Covered Unit: X Employee 344 Employee and Spouse Employee and Child X Family Number of Employees 344 749						
	b.	Covered Benefits: Medical Prescription Drug						
	c.	Minimum Annual Aggregate Deductible shall be determined by the following schedule:						
		YEES MINIMUM ANNUAL AGGREGATE DEDUCTIBLE an 250 but						
	less that More th	and and an						
	d.	Annual Aggregate Group Stop Loss Amount \$N/A						
	e.	Annual Aggregate Maximum Coverage \$N/A						
8.	Termin	l Liability Coverage (complete only if purchasing the terminal liability option.)						
		Covered Unit: Employee Employee and Spouse Number of Employees Employees						
For use	in IL, A	Z, IN, TX, WI, KS, MO						

		Employee and Child Family	
	Ъ.	Covered Benefits: Medical Prescription Drug	
	c.	Terminal Liability aggregate attachment point \$	
9.	Indiv	idual Group Stop Loss Coverage	
	a.	Covered Unit: X Employee Bemployee and Spouse Employee and Child X Family Number of Em 344 749	ployees
	b.	Covered Benefits: Medical Prescription Drug	· ·
	c. d. e.	Annual Individual Attachment/Deductible Amount Individual Lifetime Maximum Annual Individual Maximum Coverage	\$175,000 \$5,000,000 \$N/A

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Dated:	Dated at:	
By:	Witness:	
Approved by the Company to be	effective on	-
By:		
(Name)	(Title)	

JUN 1 3 2003

CITY OF WEST ALLIS
PERSONNEL/CIVIL SERVICE

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1.	Prop	osed Policyh	77	y of West A 0 South 70 th est Allis, WI	Street		
	Emp	loyee Benefit	: Plan Nai	ne: Self Fu	nded PPO Medic	al Plan	
2.	Indic insur	ate Affiliates ance, if any.	/Subsidia	ries or other	related entities to	o be included in this	
Name		Location	Relati	onship	Business	# of Employees	
<u></u>	lone					_	
3.	Does	the requested	l Group S	top-loss Pol	icy applied for re	place similar group stop-los	s
	X	No		Yes			
		nt coverage i Carrier	s with Hu	ımana	Tern	nination Date	

4.	Identify any class(es) of employees of the proposed Policyholder to be excluded from coverage under this Policy.			
	None			
5.	Identify any individual employee/dependent of the Proposed Policyholder whose coverage is to differ from the coverage applied to all other employees.			
	None			
6.	Is any person to be covered under the Policyholder's Plan known to be disabled or hospital confined as of the requested effective date?			
	□ Yes □ No			
	If yes, provide their names, nature of disability and estimated duration of the disability:			
	Underwriting is aware of disabilities and/or large claims			
COV				
COAL	ERAGE			
Types stop lo	of Aggregate and Individual Stop Loss must coincide (e.g., incurred and paid aggregate ess = incurred and paid individual stop loss).			
7.	Aggregate Group Stop-loss Coverage			
	23 Paid option			
	Incurred and paid option (claims incurred during the Policy Year which are paid during the selected period following the end of the Policy Year). 12/15 12/18 12/24			

		Terminal Liability Option (only available when selecting the incurred and paid option)				
		Monthly Aggregate Advance Option				
		Deficit Recovery Option				
		Run In. Applicant requests the Company apply all Eligible Expenses Incurred during the selected period preceding the Effective Date of the Policy to the Aggregate Stop Loss coverage.				
		□ 90 days □ 120days □ 180 days				
	a.	Covered Unit: X Employee 344 Employee and Spouse Employee and Child X Family 749				
b. Covered Benefits: Medical Prescription Drug		☐ Medical				
	c. Minimum Annual Aggregate Deductible shall be determined by the folloschedule:					
	NUMB: EMPLO More the less that More the	YEES MINIMUM ANNUAL AGGREGATE DEDUCTIBLE an 250 but 90% of the first monthly deductible multiplied by twelve				
	d.	Annual Aggregate Group Stop Loss Amount \$N/A				
	e.	Annual Aggregate Maximum Coverage \$N/A				
8.	Terminal Liability Coverage (complete only if purchasing the terminal liability option.)					
		Covered Unit: Employee Employee and Spouse Number of Employees ——————————————————————————————————				
For use in IL, AZ, IN, TX, WI, KS, MO						

		Employee and Child Family						
	b.	Covered Benefits: Medical Prescription Drug						
	c.	Terminal Liability aggregate attachment point \$						
9.	Indiv	Individual Group Stop Loss Coverage						
	a.	Covered Unit: X Employee 344 Employee and Spouse Employee and Child X Family 749	aployees					
	b.	Covered Benefits: Medical Prescription Drug	• •					
	c. d. e.	Annual Individual Attachment/Deductible Amount Individual Lifetime Maximum Annual Individual Maximum Coverage	\$175,000 \$5,000,000 \$N/A					

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Dated:	Dated at:	
Ву:	Witness:	
Approved by the Company to	be effective on	_
Ву:		
(Name)	(Title)	