23

City of West Allis
Matter Summary

7525 W. Greenfield Ave.
West Allis, WI 53214

File Number	Title	Status
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 RECOMMENDATION Approval - adopt

	MOVER	SECONDER		AYE	NO	PRESENT	EXCUSED
ACTION DATE:	M	D	Barczak	✓			
			Czaplewski	✓			
8-5-03			Kopplin	✓			
	✓		Lajsic	✓			
			Narlock				
			Reinke				✓
			Sengstock				
			Trudell				
			Vitale				
			Weigel				
			TOTAL	4			1

SIGNATURE OF COMMITTEE MEMBER (RECORDER)

Chair Vice-Chair Member

COMMON COUNCIL ACTION Adopt

	MOVER	SECONDER		AYE	NO	PRESENT	EXCUSED
ACTION DATE:			Barczak	✓			
	✓		Czaplewski	✓			
			Kopplin	✓			
8-5-03			Lajsic	✓			
			Narlock	✓			
			Reinke				✓
		✓	Sengstock	✓			
			Trudell				✓
			Vitale	✓			
			Weigel	✓			
			TOTAL	8			2

cc: admin, personnel, finance

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

Resolution

7525 W. Greenfield Ave.
West Allis, WI 53214

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 August 5, 2003

Paul M. Ziehler, CAO, Clerk/Treasurer

APPROVED August 14, 2003

Jeannette Bell, Mayor

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 Policyholder: City of West Allis
   770 South 70th Street
   West Allis, WI 53214

   Employee Benefit Plan Name: Self Funded PPO Medical Plan

2. Indicate Affiliates/Subsidiaries or other related entities to be included in this insurance, if any.

Name	Location	Relationship	Business	# of Employees
None				

3. Does the requested Group Stop-loss Policy applied for replace similar group stop-loss coverage or a fully insured plan?

   X No ☐ Yes

   Current coverage is with Humana
   Prior Carrier _____ Termination 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._____

COVERAGE

Types of Aggregate and Individual Stop Loss must coincide (e.g., incurred and paid aggregate stop loss = incurred and paid individual stop loss).

7. Aggregate Group Stop-loss Coverage

☐ 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: Number of Employees

X	Employee	344
☐	Employee and Spouse	
☐	Employee and Child	
X	Family	749

b. Covered Benefits:
☐ Medical
☐ Prescription Drug

c. Minimum Annual Aggregate Deductible shall be determined by the following schedule:

NUMBER OF EMPLOYEES	MINIMUM ANNUAL AGGREGATE DEDUCTIBLE
More than 250 but less than 500	90% of the first monthly deductible multiplied by twelve
More than 500	85% 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.)

a. Covered Unit: Number of Employees

	Employee	
☐	Employee and Spouse	

- ☐ Employee and Child _____
  Family _____

b. Covered Benefits:
- ☐ Medical
- ☐ Prescription Drug

c. Terminal Liability aggregate attachment point $_____

9. Individual Group Stop Loss Coverage

a. Covered Unit: Number of Employees

X	Employee	344
☐	Employee and Spouse	
☐	Employee and Child	
X	Family	749

b. Covered Benefits:
- ☐ Medical
- ☐ Prescription Drug

c.	Annual Individual Attachment/Deductible Amount	$175,000
d.	Individual Lifetime Maximum	$5,000,000
e.	Annual Individual Maximum Coverage	$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 on_____

By:_____
(Name) (Title)

For use in IL, AZ, IN, TX, WI, KS, MO

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1. Proposed Policyholder: City of West Allis
   770 South 70th Street
   West Allis, WI 53214

   Employee Benefit Plan Name: Self Funded PPO Medical Plan

2. Indicate Affiliates/Subsidiaries or other related entities to be included in this insurance, if any.

Name	Location	Relationship	Business	# of Employees
None				

3. Does the requested Group Stop-loss Policy applied for replace similar group stop-loss coverage or a fully insured plan?

   X No ☐ Yes

   Current coverage is with Humana
   Prior Carrier _____ Termination Date

For use in IL, AZ, IN, TX, WI, KS, MO

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

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❑ 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:

		Number of Employees
X	Employee	344
❑	Employee and Spouse	
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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.)

a. Covered Unit:

		Number of Employees
	Employee	
❑	Employee and Spouse	

- ☐ Employee and Child _____
  Family _____

b. Covered Benefits:
- ☐ Medical
- ☐ Prescription Drug

c. Terminal Liability aggregate attachment point $_____

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a. Covered Unit: Number of Employees

X	Employee	344
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Dated:_____ Dated at:_____

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☐	Employee and Spouse	

- ☐ Employee and Child _____
  Family _____

b. Covered Benefits:
- ☐ Medical
- ☐ Prescription Drug

c. Terminal Liability aggregate attachment point $_____

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