Medical Plan Data Collection

For NATM Association Health Plan Evaluation

MARSH & McLENNAN AGENCY

Company Information:

Company Name:	
Address:	
Primary Contact / Title:	

Please list all states where you have active full time employees:

State	# of Employees

Employee Count:

# Full Time Employees (Working average of 30 or more hours per week.)	
# Part Time Employees	
# Variable Hour Employees	
# Piecemeal Employees	
Total # of Employees	

Current Medical Insurance Plan Information:

Current Insurance Carrier:	Renewal Date:
# Medical Plans Currently Offered: _____	Are plans □ Fully Insured □ Level Funded □ Self-Funded

(Complete the following for your current medical plans or attached a copy of your benefit summary for each plan.)

Current Medical Plans Offered:	Plan #1		Plan #2		Plan #3		Plan #4	
Annual In Network Deductible: Employee: Family:								
Coinsurance Percentage:								
Maximum Annual Out of Pocket: Employee: Family:								
Physician Office Visit Copay:								
Emergency Room Copay:								
Pharmacy Copays:								
Is this plan a high deductible health plan (HDHP)								
Do you offer a Heath Savings Account (HSA)?								
Does the employer contribute to the HSA? If yes, please indicate amount by monthly contribution:								
Monthly Enrollment & Premium:	**Number Enrolled**	**Monthly Premium**	**Number Enrolled**	**Monthly Premium**	**Number Enrolled**	**Monthly Premium**	**Number Enrolled**	**Monthly Premium**
Employee: Employee + Spouse: Employee + Child(ren): Employee + Family: *(If plan includes 3 tier rates, please write in as Employee, Employee +1 and Employee/Family.)*								
Monthly Employee Premium Contribution: Employee: Employee + Spouse: Employee + Child(ren): Employee + Family: *(If plan includes 3 tier rates, please write in as Employee, Employee +1 and Employee/Family.)*								

Completed forms should be returned to jamie.conover@marshmma.com