**Attachment C - Insurer Acknowledgment**

**Instructions:**

1. Check “Agree” or “Disagree” to each requirement as appropriate.
2. Complete the “ACKNOWLEDGE AND ACCEPT” section:
	* Print company name.
	* Print the name of the representative signing this form (must be authorized to legally bind the company).
	* Sign and date.

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| **Supplemental Insurance Requirements** | **Agree** | **Disagree** |
| A. Insurer agrees to all Wisconsin Department of Employee Trust Funds (Department) terms and conditions in Attachment F. **Exceptions to the terms and conditions language will not be considered**. Any clarifications to the terms and conditions must be sought and determined by ETF prior to the submission of the proposal. | ☐ | ☐ |
| B. Insurer understands that the Department is in the process of implementing Benefitfocus’ Benefitplace eligibility and enrollment software and service and the contracted supplemental vendors will need to submit data to and/or receive data to/from the Department and/or Benefitfocus.Insurer understands that the contracted supplemental vendors will be required to have the ability to provide and receive repeatable, automatable data interchange with the Department and/or Benefitfocus.Are you a part of the Benefitfocus Benefit Catalog Vendor program? If so, please provide us with your vendor or partner identification number. | ☐ | ☐ |
| ☐* Yes
 | * No
 |
| C. Insurer agrees to all responsibilities and requirements outlined in this document, *S*[*upplemental Insurance Guidelines* (ET-7422)](https://etf.wi.gov/resource/supplemental-insurance-plans-guidelines), includingall Attachments A through H. | ☐ | ☐ |
| 1. Insurer has the ability to exchange data electronically with existing or emerging State of Wisconsin benefits systems for payroll and annuities, including but not limited to:
	1. Exchange of enrollment data in the 834-eligibility file format.
	2. Reconciliation of premiums.
	3. Flexibility to accommodate retroactive enrollment changes which may result in premium and/or claim adjustments.
 | ☐ | ☐ |
| E. Insurer agrees not to modify benefits or premiums during the coverage period, unless such change is necessary to comply with state or federal law, regulation or court order. | ☐ | ☐ |
| F. Insurer agrees to satisfy payment of the annual administrative fee of one percent (1%) of the *estimated* total yearly premium collected by Insurer, assessed by ETF for administration of the plan within 30days of receipt of invoice. | ☐ | ☐ |
| G. Insurer has submitted payment of $5,000 to ETF for each proposalsubmitted as payment for the third-party actuarial review fee. Checks should be made out to ETF’s third-party actuary Milliman, Inc. and | ☐ | ☐ |

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| submitted along with Insurer’s Proposal by 2:00 p.m. CST on the last Business Day in January. See ET-7422 Section 7.D. |  |  |
| H. Insurer has no outstanding debts to ETF or ETF’s third-party actuary. | ☐ | ☐ |
| I. Insurer agrees to submit accurate claims and provider data to ETF’sdata warehouse vendor for internal business use, upon ETF request. | ☐ | ☐ |
| J. Insurer agrees to provide all reports to ETF as laid out in Attachment D of this document with data from ETF subscribers, notthe Insurer’s book of business. | ☐ | ☐ |
| K. Insurer understands that Attachment E – Data Warehouse File Requirements are a sample provided using supplemental dental data file requirements and agrees to provide similar data file requirements for supplemental vision and/or accident as agreedupon with ETF. | ☐ | ☐ |
| L. Insurer agrees to establish a website for ETF’s Eligible Employees dedicated to providing information about the benefit being offered, how to apply for the benefit and any other applicable information forETF’s Eligible Employees. | ☐ | ☐ |
| M. Insurer agrees to send informational materials to Eligible Employees at ETF’s discretion (i.e. in the event of a large-scale error or legislative change, upon the Insurer’s acceptance into or termination from the program, etc.) via U.S. mail unless otherwise agreed to byETF. | ☐ | ☐ |
| N. Insurer acknowledges that a contract must be signed by the Insurer prior to the annual May Board meeting where the Board willdetermine one (1) Insurer/Proposer to contract with for each type of supplemental insurance for the following plan year. | ☐ | ☐ |

By signing hereunder, the Insurer hereby agrees to the responsibilities as outlined above.

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| **ACKNOWLEDGE AND ACCEPT:** |
| This form has been reviewed by me and shall become part of the final Contract. I am a duly authorized representative of my company and have the authority to legally bind my company. I hereby acknowledge and accept responsibility for the accuracy of the responses given above. I further accept that my company’s Proposal *may* be rejected on the grounds that any item listed above is marked as“Disagree.” I have specified and provided a reason for any answer marked as “Disagree” in my company’s Proposal. |

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| Proposer Company Name: | Click or tap here to enter text. |
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| Name & Title of Authorized Representative: | Click or tap here to enter text. |
|  |  |
| Authorized Representative Signature: |  |
|  |  |
| Signature Date: | Click or tap here to enter text. |