**Department of Employee Trust** **Funds**

P.O. Box 7931

Madison, WI 53707-7931

**Appendix 10**

**Pro Forma Contract by Authorized Board**

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| **Request for Proposal Number/Contract Number/Service:** ETD0050 IYC Medicare Advantage and ETD0051 Medicare Plus |
| **Authorized Board:** Group Insurance Board |
| **Contract Period:** xxxx – December 31, 2028 with the option for renewal for two additional two-year terms |

1. This Contract is entered into by the State of Wisconsin Department of Employee Trust Funds (Department) on behalf of the State of Wisconsin Group Insurance Board (Board), and xxx (Contractor), whose address and principal officer appear below. The Department is the sole point of contact for this Contract.

2. Whereby the Department agrees to direct the purchase and Contractor agrees to supply the Contract requirements in accordance with the documents specified in the order of precedence below, which are hereby made a part of this Contract by reference.

3. For purposes of administering this Contract, the order of precedence is:

(a) This Contract;

(b) Exhibit A, Contract Clarifications;

(c) Exhibit 1 - State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement with the revision date of ??? 2025;

(d) Request for Proposal (RFP) ETD0050 / ETD0051 dated March 7, 2024; and,

(e) Contractor’s Proposal dated xxxx.

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| **State of Wisconsin****Department of Employee Trust Funds** |   | **Contractor** |
| Authorized Board: | Legal Company Name: |
| **State of Wisconsin Group Insurance Board** |  *SAMPLE* |
| By *(Name):* | Trade Name or dba: |
|   |   |
| Signature: | Taxpayer Identification Number: xxx |
| *SAMPLE* |  |
| Date of Signature:  | Contractor Address (Street Address, City, State, Zip):  |
| Contact Beth Bucaida if questions arise: (608) 267-3933 |
|  | Name & Title (print name and title of person authorized to legally sign for and bind Contractor):  |
|  |
|  |
|  | Signature: |
|  | *SAMPLE* |
|  |  | Date of Signature:  |
|  |  | Email: Phone:  |