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| **ANNEX VI****TECHNICAL PROPOSAL SUBMISSION FORM***Request for Proposal (RFP) no: RFP21-072* |

* + 1. **Background**
	1. Contact

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| **Registered name of the Organisation:****(Please provide registration document)** |  |
| **Year established:** |  |
| **Full Physical Address:** |  |
| **Postal Address:** |  |
| **Telephone contact:** |  |
| **Email address:** |  |
| **Contact person:** |  |
| **Number of employees:** |  |
| **Proprietor’s/shareholder’s details:** |  |

* 1. Legal Registration

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| **Place of registration &****registration No.** | **Date of Incorporation** | **Directors’ names** |
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**Please provide evidence of certification of compliance with legal obligations (insurance, work safety, accounting monitoring) when applicable.**

* + 1. **Current clients**

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| **How many people are covered by one of your international health insurance policies?** |
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| **What is their geographic distribution?** |
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| **Who are your main clients? Please state the number of years that they have been with you, the number of people insured, the geographic zones covered, the extent of the coverage, etc.** |
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**Reference 1:**

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| **Name and address of International Organisation or similar major client:** |  |
| **Name of reference person and contact details:** | **Name:****Job title:****Email:****Telephone:** |
| **Description of actual services provided by your company. Please provide details, expanding as necessary:** |  |

**Reference 2:**

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| **Name and address of International Organisation or similar major client:** |  |
| **Name of reference person and contact details:** | **Name:****Job title:****Email:****Telephone:** |
| **Description of actual services provided by your company. Please provide details, expanding as necessary:** |  |

**Reference 3:**

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| **Name and address of International Organisation or similar major client:** |  |
| **Name of reference person and contact details:** | **Name:****Job title:****Email:****Telephone:** |
| **Description of actual services provided by your company. Please provide details, expanding as necessary:** |  |

* + 1. **Description of your teams**

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| **Number of managers in charge of processing the files (memberships, invoices and payments)** |
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| **How would the team be organised for this account, both daily and during emergencies, including round-the-clock, week-ends and holidays?** |
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| **Give a few examples of indicators of the level of services currently used by your main comparable clients** |
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* + 1. **Claims handling and reimbursement arrangements**

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| **How do complementary reimbursement claims work?**  |
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| **What reimbursement management information can you provide :**1. **to SPC?**
2. **to staff and their families?**
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| **How do you inform subscribers that their reimbursements have been completed and how long does reimbursement take on average? What is your guaranteed maximum processing time? How do you handle periods of heavy demand?** |
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| **Are you able to make reimbursements in different currencies? Indicate those currencies mentioned in the Terms of Reference that are not covered.** |
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* + 1. **Computer and online services**

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| **What are your current computer systems and infrastructures?** |
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| **What advantages can your systems provide to customers? (Access to management data, instant updates on management information, on-line management of claims, Internet links for customers, etc.)** |
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| **What are the guarantees you can provide regarding the proper management of data collection and the respect for confidentiality?** |
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| **What languages are your services available in?** |
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* + 1. **Please provide proposed coverage:**

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| **CORE PLAN** | **Current Coverage** | **Proposed Coverage** |
| Maximum plan benefit EUR (€)  | No limit  |  |
| Public Hospital - Hospital room (standard/double) | Full refund  |  |
| Private Hospital - Hospital room (standard/double) | Full refund  |  |
| Accommodation costs for one parent staying in hospital with an insured child under 18 | Full refund  |  |
| Intensive care | Full refund  |  |
| Prescription drugs and materials(in-patient and day-care treatment only)  | Full refund  |  |
| Surgical fees, including anaesthesia and theatre charges | Full refund  |  |
| Physician and therapist fees(in-patient and day-care treatment only)  | Full refund  |  |
| Surgical appliances and materials | Full refund  |  |
| Diagnostic tests(in-patient and day-care treatment only)  | Full refund  |  |
| Bariatric surgery(in-patient and out-patient treatment)  | 80% refund  |  |
| Rehabilitation treatment(in-patient, day-care and out-patient treatment; must commence immediately after discharge after the acute medicaland/or surgical treatment ceases) | Full refund  |  |
| In-patient cash benefit (per night)(where treatment has been received free of charge)  | €100, max. 25 nights  |  |
| Organ transplant | Full refund  |  |
| Emergency in-patient dental treatment  | Full refund  |  |
| Day-care treatment | Full refund  |  |
| Kidney dialysis | Full refund  |  |
| Out-patient surgery | Full refund  |  |
| Local ambulance  | Full refund  |  |
| CT and MRI scans(in-patient treatment)  | Full refund  |  |
| PET and CT-PET scans(in-patient treatment)  | Full refund  |  |
| Oncology(in-patient, day-care and out-patient treatment)  | Full refund  |  |
| - Professional fees  | 80% refund  |  |
| - Purchase of a wig, prosthetic bra or other external prosthetic device for cosmetic purposes  | €200 per lifetime  |  |
| Routine maternity(in-patient and out-patient treatment)  | Full refund  |  |
| - Professional fees  | 80% refund  |  |
| Complications of pregnancy and childbirth | Full refund  |  |
| - Professional fees  | 80% refund  |  |
| Newborn care(in-patient and out-patient treatment)  | Full refund  |  |
| - Professional fees  | 80% refund  |  |
| Midwife visits(cover is provided for 12 visits before the birth and 10 visits after the birth)  | 80% refund  |  |
| Rehabilitation of the pelvic floor following birth(provided by a midwife or physiotherapist)  | Max. 10 visits, up to €300  |  |
| Palliative care | Full refund  |  |
| Nursing at home or in a convalescent home  | Full refund  |  |

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| **OUT-PATIENT PLAN** | **Current Coverage** | **Proposed Coverage** |
| Maximum plan benefit EUR (€)  | No limit  |  |
| Medical practitioner fees  | 80% refund  |  |
| Prescription drugs(Prescription drugs are those which legally can only be purchased when you have a doctor’s prescription)  | 80% refund  |  |
| Prescribed oral contraceptives and contraceptive implants  | 80% refund  |  |
| Specialist fees  | 80% refund  |  |
| Prescribed physiotherapy(initially limited to 12 sessions per condition; limit also applies to prescribed and non-prescribed physiotherapy sessions,where combined) | 80% refund  |  |
| Vaccinations  | 80% refund  |  |
| Psychiatrist fees(must be clinically significant and has to be prescribed by a doctor)  | 80% refund  |  |
| Prescribed orthophony therapy | 80% refund  |  |
| Pre-natal classes(limited to 8 sessions in preparation of the first birth and provided by a midwife)  | 300 €, max. 8 sessions  |  |
| Post-natal classes(limited to 2 sessions within 8 weeks following the first delivery and provided by a midwife)  | 300 €, max. 2 sessions  |  |
| Diagnostic tests  | 80% refund  |  |
| CT and MRI scans(out-patient treatment)  | 80% refund  |  |
| PET and CT-PET scans(out-patient treatment)  | 80% refund  |  |
| Prescribed medical aids and other prostheses  | 80% refund  |  |
| - Prescribed medical aids for the treatment of sleep disorders | 80% refund  |  |
| Infertility treatment | 80% refund, up to €2,500per attempt |  |
| - Up to four In-Vitro Fertilization attempts per lifetime to achieve pregnancy  | Max. 4 attempts per lifetime  |  |
| - One artificial insemination per attempt, with a maximum of 6 attempts per lifetime to achieve pregnancy  | Max. 6 attempts per lifetime  |  |
| Health and wellbeing checks including screening for the early detection of illness or disease. | 80% refund  |  |
| Prescribed glasses and contact lenses including eye examination | **90% refund, max. €800** |  |

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| **DENTAL PLAN** | **Current Coverage** | **Proposed Coverage** |
| Dental treatment  | 90% refund  |  |
| Dental surgery  | 90% refund  |  |
| Orthodontic treatment, dental prostheses including implants  | 90% refund, max. €2,000  |  |

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| **OVERSEAS MEDICAL EVACUATION (OME)** | **Current Coverage** | **Proposed Coverage** |
| Maximum plan benefit EUR (€)  | Max. €3,000 per event  |  |
| Medical evacuations to Australia, New Zealand or New Caledonia and to Philippines forMicronesia (lodging and meals included), where the necessary treatment is not available locally. | Full refund  |  |

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| **ADDITIONAL CORE PLAN SERVICES** | **Current Coverage** | **Proposed Coverage** |
| **Employee Assistance Programme** offers access to a range of 24/7 multilingual support services as follows:• Confidential professional counselling (in-person, phone, video, on-line chat and email)• Legal and financial support services• Critical incident support• Wellness website access | Services available |  |
| **Travel Security Services** offers 24/7 access to personal security information and advice for all your travel safety queries. This includes:• Emergency Security Assistance Hotline • Country intelligence and security advice• Daily security news and travel safety alerts | Services available  |  |

* + 1. **Certification**

I, the undersigned, warrant that the information provided in this form is correct and, in the event of changes, details will be provided as soon as possible:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Functional Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Seal/Stamp (if any)

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