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| **ANNEX VI**  **TECHNICAL PROPOSAL SUBMISSION FORM**  *Request for Proposal (RFP) no: RFP21-073* |

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

|  |  |
| --- | --- |
| **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

|  |  |  |
| --- | --- | --- |
| **Place of registration &**  **registration No.** | **Date of Incorporation** | **Directors’ names** |
|  |  |  |

**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 life & disability insurance policies?** |
|  |
| **What is their geographic distribution?** |
|  |
| **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.** |
|  |

**Reference 1:**

|  |  |
| --- | --- |
| **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:**

|  |  |
| --- | --- |
| **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:**

|  |  |
| --- | --- |
| **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**

|  |
| --- |
| **Number of managers in charge of processing the files (memberships, invoices and payments)** |
|  |
| **View, over the past three years, of the volumes handled directly by your teams in receipts and in payments by type of coverage** |
|  |
| **Give a few examples of indicators of the level of services currently used by your main comparable clients** |
|  |
| **Contact: do you have a phone centre that operates in both French and English? Does it have dedicated managers?** |
|  |

* + 1. **Claims handling**

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| --- |
| **Please explain your process for handling claims.**  **Please provide model claims forms, pro-forma invoices, etc.** |
|  |
| **What reimbursement management information can you provide :**   1. **to SPC?** 2. **to staff?** |
|  |

* + 1. **Computer and online services**

|  |
| --- |
| **What are your current computer systems and infrastructures?** |
|  |
| **What languages are your services available in?** |
|  |
| **What are the guarantees you can provide regarding the proper management of data collection and the respect for confidentiality?** |
|  |
| **Do you have an on-line system that would allow us to register enrolments and departures ourselves?** |
|  |

* + 1. **Please provide table of benefits:**

**LIFE AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY**

|  |  |  |
| --- | --- | --- |
|  | **Current** | **Proposed** |
| Lump Sum in the Event of Death or Total and Irreversible Loss of Autonomy (regardless of family status) | **200% of annual gross salary** |  |

**DAILY BENEFITS FOR TOTAL INCAPACITY FOR WORK COVERAGE**

**Amount:**

|  |  |  |
| --- | --- | --- |
|  | **Current** | **Proposed** |
| Waiting Period | 90 days |  |
| Daily benefit paid : 1/365e of the declared salary on the day before the start of the sick leave (regardless of family status) | 50 % |  |

**Daily benefits cease to be due:**• in the event of a return to work on a full-time basis or when the Insurer considers that the Covered Person  
is able to return to work on a full-time basis; or  
• on the 365th day following the date of cessation of work; the disability annuity may then be allocated to  
the Covered Person in accordance with the provisions of the present contract; or  
• on the date of allocation by the Insurer or a Social Security plan of a disability pension, incapacity annuity,  
or old-age pension from a basic plan or an unemployment pension; or  
• on the date of the Covered Person’s death.

**PERMANENT DISABILITY RESULTING FROM ACCIDENT**

|  |  |  |
| --- | --- | --- |
|  | **Current** | **Proposed** |
| Permanent and Total Disability that occurred no later than one year after the date of the accident. | **200% of annual gross salary** |  |

* + 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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