COLLIN COUNTY

Office of the Purchasing Agent
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ADDENDUM NO. TWO (2)

Short-and Long-Term Disability

RFP NO. 2024-335

Effective: September 9, 2024

Change: Attachment C-Disability Pricing Information

From: Attachment C-Disability Pricing Information

To: ~~Attachment_C_Disability_Pricing_Information~~Attachment C_Disability Pricing Information Updated v2

Please note all other terms, conditions, specifications, drawings, etc. remain unchanged.

Sincerely,
Michelle Charnoski, NIGP-CPP, CPPB
Purchasing Agent

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ATTACHMENT C – DISABILITY PRICING INFORMATION

COLLIN COUNTY, TEXAS

INSTRUCTIONS

Answer all questions fully, clearly, and concisely unless a specific question is not applicable to the service you are proposing to provide. If you are unable to answer a question or the question does not apply, you should indicate either not applicable, or the reason why the question was not answered.

Each response must immediately follow the respective question. Do not refer to other parts of your proposal for the answers. You may not modify either the order or language of the question.

1. FINANCIAL INFORMATION

1.1 Short-Term Disability Insurance Administration – Claims Administration Only
Quote coverage at 67% of weekly earning and no maximum.

	2025	2026	2027	2028	2029	2030	2031
67%	$	$	$	$	$	$	$
Other (specify)							

1.1.1 Clearly indicate the method of calculating the increase for each period in your response from 1.1.

Answer:

1.2 Long-term Disability Insurance Administration – Claims Administration Only
Quote monthly premium rate per $100 of covered payroll; Coverage at 66 and 2/3% of monthly earnings and for a $100 weekly minimum and $15,000 weekly maximum.

	2025	2026	2027	2028	2029	2030	2031
66 and 2/3 %/$15,000 weekly maximum	$	$	$	$	$	$	$
Other (specify)							

1.2.1 Clearly indicate the method of calculating the increase for each period in your response from 1.2.

Answer:

1.3 If the Employee Assistance Program fee is not included in the administration fee for short or long-term disability, specify the fee here.

	2025	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
Employee Assistance Program	$	$	$	$	$	$	$

1.4 Indicate the fee for programs listed in Attachment B – Disability Questionnaire # 1.3.

	2025	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
Other (specify)	$	$	$	$	$	$	$
Other (specify)	$	$	$	$	$	$	$
Other (specify)	$	$	$	$	$	$	$