

## REQUEST FOR COMPETITIVE SEALED PROPOSALS

ITEM: Student Insurance

DESCRIPTION: Insurance for Students in Athletics and other UIL Activities, and School Sponsored Events

DEADLINE: Wednesday, May 26, 2021 11:00 a.m.

The Lyford Consolidated Independent School District (LCISD) is accepting proposals for insurance coverage for student body and all students (boys and girls) participating in Interscholastic League Athletics sponsored by LCISD. Includes pre and off-season scheduled athletic training periods; spring football practice, and all other Interscholastic League Athletics; including senior high school football and travel connected with participation in the Interscholastic Sports involved in school supervised and sponsored vehicle to and from games or practice. (No insurance list required). Effective date of first scheduled preschool Interscholastic League Athletic practice year 2021. Also to include all UIL activities and school sponsored events.

You must use the proposal form included therein as your response to this request. Please mail proposals to:

Lyford Consolidated Independent School District  
Attn: Elisa Rosas, Chief Financial Officer  
P.O. Drawer 220  
Lyford, TX 78569

Proposals will be received and opened in the Administrative Building at 8240 Simon Gomez, Lyford, TX at 11:00 a.m. Wednesday, May 26, 2021. Any proposals received after the time set for opening will be returned to vendor unopened.

LCISD reserves the right to accept the proposal most advantageous to the LCISD or to reject any or all proposals and to waive all formalities in bidding.

# LYFORD CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

## SPECIFICATIONS AND REQUIREMENTS

### I. SCOPE AND INTENT

It is the intent of the Lyford Consolidated Independent School District (LCISD) to acquire Athletic Student Insurance for Coverage for student body and all students (boys and girls) participating in Interscholastic League Athletic sponsored by LCISD. Includes pre and off-season scheduled athletic training periods; spring football practice, and all other Interscholastic League Athletics; including senior high school football and travel connected with participation in the Interscholastic Sports involved in school supervised and sponsored vehicle to and from games or practice. (No insurance list required). It will also include all other UIL activities and school sponsored events.

### II. REQUIREMENTS

A. Period of Coverage: We are requesting coverage to begin with the first schedule day pre-school Interscholastic League Athletic practice or August 1, 2021 and end with the last day of July, 2022.

B. Coverage: Coverage is for all sports for 7th through 12th grades. No list is required. Coverage includes persons trying out. Also to include all UIL Activities, school sponsored events and community service activities by the Positive Redirection Center/Boot camp and any other LCISD instructional group.

C. Voluntary Plan Coverage:

1. Students: Any student who is enrolled in any public, private or parochial school at any grade level through the 12th grade, including pre-schools, kindergartens and nursery schools.
2. Cancellation: The insurance is non-cancellable. There is no premium reduction for any individual who enrolls later in the year.

## ATHLETIC/STUDENT INSURANCE

### Specification

#### III. Voluntary Plan Coverage (Cost Paid by Parents):

At-School Coverage: Each covered person for whom the premium for school time coverage has been paid will be covered for injury which occurs (1) on or after the later of the Policy Date, or the date the premium for the covered person is received by the policyholder, (2) during the regular school term while the covered person is:

- a. On the school premises:
  1. During the hours when school is in session; or
  2. During the hours when school is not in session; if he/she is participating in or attending any school sponsored activity.
- b. Away from the school premises if he/she is participating in or attending any school activity.
- c. Traveling directly and uninterruptedly to or from his/her residence and the school premises on days when he/she has regularly scheduled classes or work; if travel is by any mode of transportation other than school bus, travel time will be limited to one hour before his/her first class or the beginning of his/her work period and one hour after he/she is dismissed or his/her work period ends.
- d. Traveling directly, uninterruptedly and under the direct supervision of a qualified school appointed official to or from a school sponsored activity in a vehicle approved by the school.

24-Hour Coverage: Each covered person for whom the premium for 24-hour coverage has been paid will be covered for injury which occurs (1) on or after the later of the policy date or the date the premium for the covered person is received by the policyholder, and (2) before one year after the policy date.

Football coverage: Each covered person for whom the premium for football range has been paid will be covered for injury which occurs on or after the first day of scheduled high school football.

#### IV. Policy Exclusions

Student accident insurance is the best medical insurance buy available anywhere, at an annual cost of less than the monthly premium often charged for comparable coverage, in order to keep this valuable coverage within the reach of all students, reimbursement will not be made (nor is any premium charged for) any loss, fatal or non-fatal, which is caused by or results from:

1. Illness or disease in any form; ptomaine or bacterial infections (except through an open visible wound); over-exertion or fainting.
2. Suicide or attempt there at while sane or insane; mental or nervous disorders.
3. Hernia, regardless how caused, cysts, tumors, blisters or boils.
4. Travel in or upon any two (2) or three (3) wheeled motor vehicle.
5. Eyeglasses, corrective lenses or prescription therefore.
6. Prescription drugs and medicines not actually administered to the patient in the hospital or in the office of a licensed physician.
7. Injury occurring while under influence of a controlled substance unless administered or prescribed by a licensed physician and taken in the recommended dosage
8. Play of or practice for interscholastic high school football or intercollegiate football except when a specific additional premium charge is paid.
9. Injury occurring as a result of riding as a passenger or otherwise in or on any vehicle or device for aerial navigation except as a fare paying passenger on a regularly scheduled commercial air carrier.
10. An accident which is compensable under any Workmen's Compensation, occupational disease or similar act or law.
11. Nuclear reactions or radiation contamination, war, declared or undeclared, invasion, civil war, rebellion, insurrection or not; or while a member of the armed services provided, however, a pro rate refund of premium shall be made in the event a covered person enters the Military Service.
12. Commission of or attempt to commit a felony or while being engaged in an illegal occupation.

V. ESTIMATES OF PARTICIPATION

A. We are estimating the following as our participation in each of the following areas:

1. Varsity and Junior Varsity Football 75
2. Middle School Football (7th and 8th) 58
3. All other sports 553
4. Cheerleaders 16
5. Band, Drill Teams 232

B. We have no exact number of participants for all the other UIL activities and Community service activities.

C. The total student population as of 05-07-21 is 1,479. We have one high school and it is classified as 3A; one middle school, and one elementary school.

D. The premium cost and total claims for the following years:

<u>Policy Year</u>	<u>Premium</u>	<u>Total Claims Paid</u>	<u>Loss Ratio</u>
2016-2017	\$43,575.00	\$40,997	94.00%
2017-2018	\$43,575.00	\$39,532	91.00%
2018-2019	\$43,575.00	\$47,504	109.00%
2019-2020	\$48,000.00	\$47,499	99.00%
2020-2021	\$57,500.00	\$44,560	77.00%

VI. REQUEST FOR PROPOSALS

A. We are requesting two bids from each company. You are not required to give two bids. The REQUESTED PLAN bid should duplicate exactly what we are requesting which is under the Requested Plan column of the Quotation Form under Coverage and Benefits. The ALTERNATIVE PLAN bid can be any plan you choose to offer. All items on the attached Quotation Form must be answered for each quotation.

DO NOT ANSWER ANY QUESTIONS BY SAYING "SEE BROCHURE". ONLY ANSWERS ON THE QUOTATION FORM SHEETS WILL BE CONSIDERED.

The policy issued by the selected company shall provide coverage exactly as indicated in the answers in the Quotation Form, in the event of any variation the Company or completing agent warrants that the policy will be amended to comply with specifications for they will be responsible for providing benefits as described in the ANSWERS TO THE QUOTATION FORM.

B. You are to use the attached herein provided Quotation Form for your response. You may attach any additional information or comments that you desire. You must answer the questionnaire and coverage and benefits sections which are part of the Quotation Form. Therefore, they must be submitted all together as part of your proposal, as failure to do so will withdraw your proposal from consideration.

VII. PROPOSALS/APPROVAL

1. All accepted proposals will be tabulated and awarded as provided under the Section VI, Selection Criteria Section.
2. If no acceptable proposals are received, the proposal acquisition will be re-advertised seeking an acceptable proposal.
3. The District reserves the right to accept or reject all or any proposal, waive minor technicalities, and award the proposal to best serve the interest of the District.

VIII. SELECTION CRITERIA

A. General

The proposals will be evaluated by specific criteria. The LCISD shall use the following selection criteria to select the offeror that offers the best value to LCISD. The scores assigned to each selection criteria are indicated in the selection criteria and scores chart attached herein.

Criteria is assigned a score of 1 to up to the maximum points as indicated in the assigned points column. The scores of each criterion will then be totaled for each proposal; and the proposal receiving the highest score will be considered to be the proposal which offers the best value for the LCISD.

After determining the offeror that offers the best value to the LCISD, the LCISD and its architect or engineer may discuss with the selected offeror options for cost reduction. If the LCISD is unable to reach a contract agreement with the selected offeror, the LCISD shall terminate further discussions and proceed to the next offeror in the order of the selection rankings until a contract agreement is reached or all proposals are rejected.

The award on contract, if over \$25,000.00, will require approval by the Board of Trustees.

B. PROCEDURES/STEPS It is the intent of LCISD to follow these procedures/steps to award contract:

1. All proposals received will be open and read aloud.
2. Evaluation Committee will evaluate proposals, summarize, and rank the proposals as to the best value proposal to the LCISD.
3. Superintendent approves the ranking of the proposals and directs next step.
4. At the Superintendent's discretion, negotiation/discussion of changes in the nature of proposal, and in prices begin.
5. After negotiations/discussions are complete, the Superintendent prepares the recommendation to the Board of Trustees for contract approval.
6. Board of Trustees act on Superintendent's recommendation.
7. Contract is awarded.

C. SELECTION CRITERIA Assigned Points

- |    |                    |    |
|----|--------------------|----|
| 1. | Purchase Price     | 60 |
| 2. | Experience         | 10 |
| 3. | Past Performance   | 5  |
| 4. | Reputation/Rating  | 20 |
| 5. | Financial Strength | 5  |

QUESTIONNAIRE

- A. Do you have an 800 number for questions about claims? \_\_\_\_\_ yes \_\_\_\_\_ no  
If no, do you have a local number or a number we can call collect? \_\_\_\_\_ yes \_\_\_\_\_ no
- B. Do you assign local representatives to each school district to answer questions? \_\_\_\_\_ yes \_\_\_\_\_ no If  
yes, please name the local representative  
Name \_\_\_\_\_  
Co. Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone No. \_\_\_\_\_
- C. Do you have someone who can periodically review problem claims on site? \_\_\_\_\_ yes \_\_\_\_\_ no
- D. Where are your claims paid from?
- E. What is your guaranteed turnaround time for paying claims?
- F. Do you require a form to be filled out by each doctor or hospital for the same claim?  
\_\_\_\_\_ yes \_\_\_\_\_ no
- G. Do you require a claim form to be filed for each accident? \_\_\_\_\_
- H. Are you registered to do business in Texas? \_\_\_\_\_ yes \_\_\_\_\_ no
- I. Is your company rated by Standard & Poor's? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, what is your rating? \_\_\_\_\_
- J. Is your company rated by A.M. Best? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, what is your rating? \_\_\_\_\_
- K. Please list four references of school districts you currently service geographically closest to us.
- L. Does your company provide monthly claim reports? \_\_\_\_\_ yes \_\_\_\_\_ no
- M. Are year-end loss reports furnished? \_\_\_\_\_ yes \_\_\_\_\_ no
- N. If there are any special features or provisions that have not been shown that your plan has to offer:
- O. If you are offering the usual and customary cost benefits, how is it determined here for the Lyford, Texas area? Please state.

STUDENT INSURANCE

QUOTATION FORM

I. QUOTE

	REQUESTED PLAN BID	ALTERNATE PLAN
A. All Athletics under UIL activity, including cheerleaders, band, and school sponsored activities		
Total Cost	\$ _____	\$ _____
B. Catastrophic Coverage		
Cost per Student	\$ _____	\$ _____
Total Cost	\$ _____	\$ _____
C. Total of A & B	\$ _____	\$ _____
D. Optional Coverage		
Braces and Appliances	\$ _____	\$ _____
Vocational and FFA	\$ _____	\$ _____
Total Cost	\$ _____	\$ _____
E. Voluntary Plan- Student and School Employees for whole year.		
1. 24-hour Coverage	\$ _____	\$ _____
2. At School Coverage	\$ _____	\$ _____
F. Other-Option for LCISD		
1. Prescription drugs	\$ _____	\$ _____
2. MRI Extended Coverage	\$ _____	\$ _____

WE THE UNDERSIGNED SUBMIT THE ABOVE PROPOSAL FOR THE ABOVE MENTIONED ITEM.

I/We have read the proposal requirements, conditions, and specifications which are an integral part of the terms of this contract.

My signature also certifies that the accompanying proposal is not the result of or affected by any unlawful act of collusion with another person or company engaged in the same line of business, or commerce, or any act of fraud punishable under current Texas codes. Furthermore, I understand that fraud and unlawful collusion are crimes under the Statue Law, and can result in fines, prison sentences, and civil damage awards.

I hereby certify that I am authorized to sign as a Representative for the Firm:

Name of Firm: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Name (Type/Print): \_\_\_\_\_

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

Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date \_\_\_\_\_

(NOTE: Also submit with this Quotation Form, the Questionnaire and the Coverages and Benefits Section attached).



ATHLETIC/STUDENT INSURANCE

COVERAGES AND BENEFITS  
(Part of Quotation Form)

The following are the coverages and benefits for the requested plan and if you choose to offer an alternative plan please fill out the blanks under the column alternative plan.

I. COVERAGES

	REQUESTED PLAN	ALTERNATIVE PLAN
1. Maximum Benefits per occurrence	\$ 25,000.00	\$ _____
2. Deductible required	None	\$ _____
3. Maximum number of days between injury and first treatment should be	90 days	_____ days
4. Standard benefit period should be at least	260 weeks	_____ weeks
5. What is the amount that will be paid as primary	None	\$ _____
6. Catastrophic Coverage:		
a. Maximum	\$5,000,000.00	\$ _____
b. Mandatory deductible and excess coverage	\$ 25,000.00	\$ _____

II. BENEFITS – MEDICAL AND DENTAL

Our requested plan bid will be of Usual Customary and Reasonable (UCR) on each, unless otherwise indicated under the Requested Plan column, of the following areas. The space is provided for you to detail any exceptions to this coverage. We do not want bids which use a sharing or percentage of expenses covered; the bid should be for 100% coverage.

QUESTIONNAIRE FORM

	REQUESTED PLAN	ALTERNATIVE PLAN
A. Doctors' Fees:		
1. Non-surgical	UCR	_____
2. Surgical	UCR	_____
3. Anesthesiologist	UCR	_____
4. Neurological Consultation	UCR	_____
 B. Hospital Expenses		
1. In-Patient		
a. Room and Board	UCR	_____
b. Prescribed Medicine	UCR	_____
c. Miscellaneous Expenses	UCR	_____
2. Out-Patient		
a. Emergency Room and Supplies	UCR	_____
b. Physiotherapy	UCR	_____
c. Non-Surgical fees	UCR	_____
d. Other	UCR	_____
 C. Ambulance Expense		
1. One trip per injury Ground Transportation	UCR	\$ _____
2. If necessary trip from one facility to another	UCR	\$ _____
 D. X-Rays - Including		
1. Interpretation	UCR	_____
2. MRI	UCR	_____

REQUESTED

ALTERNATIVE

	PLAN	PLAN
E. Dental Fees		
Per tooth	UCR	\$ _____
Maximum	UCR	\$ _____
F. Injections		
Vaccines and local anesthetics	UCR	_____
G. Braces and Appliances		
Limit per injury	UCR	\$ _____
H. Motor Vehicle Accident		
Limit - max per injury	UCR	\$ _____

III. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A. These benefits are payable for losses which occur within how many days from date of injury	365 days	_____ days
B. Loss of Life	\$ 10,000.00	\$ _____
C. Loss of Both Hands, Both Feet, or Sight of Both Eyes	\$ 20,000.00	\$ _____
D. Loss of Hand or one Foot	\$ 10,000.00	\$ _____
E. Loss of sight of one Eye	\$ 10,000.00	\$ _____

IV. OPTIONAL - EXTENDED

Dental Coverage

Usual, Customary and Reasonable to \$25,000.00 maximum

Additional Premium for Student	\$ 8.00	\$ _____
--------------------------------	---------	----------

(End of Coverages and Benefits Section)