ATTACHMENT 5

OFFEROR INFORMATION SHEET

**Offeror Information**

|  |  |
| --- | --- |
| Organization Name |  |
| Contact Person Name |  |
| Contact Person Title |  |
| Address |  |
| Phone Number |  |
| Email Address |  |
| Fax Number |  |
| Lead Consultant Name |  |
| Lead Consultant Title |  |
| Associate Consultant Name |  |
| Associate Consultant Title |  |
| Lead Pharmacist Name |  |
| Lead Pharmacist Title |  |

**Reference Information**

Provide the requested information below for three current client references for whom pharmacy benefit consultant services were provided within the past three years. The clients provided MUST be for the Lead Consultant and should be as comparable to the EUTF in terms of the following:

1. Offers active employee and retiree plans
2. State and local government or multi-employer plans
3. Number of enrolled participants
4. Number and type of prescription drug plans offered
5. Complexity of administration
6. Similar form of administrative entity (Trustee Board with dedicated Administrative Organization)
7. Geographic dispersion of participant population.

**Client #1**

|  |  |
| --- | --- |
| Client Name |  |
| Client Address |  |
| Plan Administrator Name |  |
| Phone Number |  |
| Active Employee Plans   * # of Covered Employees and Dependents * # of Prescription Drug Plans |  |
| Retiree Plans   * # of Covered Retirees and Dependents * # of Prescription Drug Plans   (non-Medicare and Medicare) |  |
| Annual Premium Volume |  |
| Description of Work Performed |  |

**Client #2**

|  |  |
| --- | --- |
| Client Name |  |
| Client Address |  |
| Plan Administrator Name |  |
| Phone Number |  |
| Active Employee Plans   * # of Covered Employees and Dependents * # of Prescription Drug Plans |  |
| Retiree Plans   * # of Covered Retirees and Dependents * # of Prescription Drug Plans   (non-Medicare and Medicare) |  |
| Annual Premium Volume |  |
| Description of Work Performed |  |

**Client #3**

|  |  |
| --- | --- |
| Client Name |  |
| Client Address |  |
| Plan Administrator Name |  |
| Phone Number |  |
| Active Employee Plans   * # of Covered Employees and Dependents * # of Prescription Drug Plans |  |
| Retiree Plans   * # of Covered Retirees and Dependents * # of Prescription Drug Plans   (non-Medicare and Medicare) |  |
| Annual Premium Volume |  |
| Description of Work Performed |  |