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DATE: 11/10/2023
RFP NUMBER: 24-021CG Part A and Part B
RFP TITLE: IBAC Medical, Dental, Vision Plans and Related Services
ADDENDUM NUMBER: 2 to Part B

Addendum #2 for RFP 24-021CG Part B
Questions and Answers

1. With the release of the Fully Insured Proposal on 10-19-23, will there be an extension to the deadline for question submission for Part B?

There are no changes to the dates in the RFP Schedule at this time.

2. It's understood that you don't want a response that simply refers to an attachment, but is it possible include attachments—in a PDF format—that demonstrate or illustrate particular responses? If so, can these attachments be included in a PDF document that is uploaded along with required spreadsheets?

As noted in the questionnaire instructions, Offerors are permitted to include a one (1) page attachment to each questionnaire with supplemental information. Offerors may include additional supplemental materials with their submission in excess of this, however, anything more than the permitted one page may be excluded during the evaluation process.

3. Can you confirm the expectation is to quote all fully insured groups with pharmacy services, If so, will pharmacy claims data be made available for review?

As noted on page 25 in the Scope of Services in this RFP, prescription drugs are carved out of all of the IBAC active and pre-Medicare medical plans. The Prescription Drug program will not be part of this IBAC RFP process (with the exception of the fully insured Medicare Advantage plans). The Medicare Advantage plans are required to provide at least Part D creditable prescription drug coverage.

4. We received two census files for SONM. Is the assumption that we should perform geo access for each file separately or should they be combined?

Please combine the two groups for the Geo Access (GeoSummary|SONM tab) in your response to this RFP.

5. We received a single file for NMRHCA which includes both commercial and Medicare members. Should we assume these should be separated by line of business for separate geo access requests being that each has an unique network?

There are separate Geo Access tabs for the different populations: Pre-Medicare, Medicare Supplemental, and MAPD.

6. Performance Guarantee #21 lists customer satisfaction. Can you please describe how the Continuous Track Program is conducted, specifically, how often, via what method (phone, email, online, etc.), and how is the survey developed? How are results tabulated and reported to vendor?

Customer Satisfaction in this PG is defined as the percent of the enrolled members who respond to the Continuous Tracking Program, rating the overall performance of their health plan as Excellent, Very Good, or Good. Standard is measured on an Employer-specific basis. Employer must maintain minimum of 10,000 enrollees for the Participant Satisfaction

Survey measure to apply. The Continuous Tracking Program will be outlined by each IBAC agency and finalized with the awarded vendor(s) during contract negotiations. Each Offeror should provide their suggested approach and reporting.

7. Performance Guarantee #26 requests Burden of Disease reporting. Can you please describe or share a sample of this report? Are there specific diseases that should be targeted?

Burden of Disease reporting needs will be outlined by each IBAC agency and finalized with the awarded vendor(s) during contract negotiations. Each Offeror should provide their suggested approach and reporting.

8. Active and pre-Medicare self-funded Medical Questionnaire Part B: 3. The questionnaire (tab 2.D, 7.3) outlines that each agency has different claims, administration billing, and banking processes. Can you please outline each of those processes by agency?

NMPSIA

• Regarding premium/fee billing, NMPSIA has 219 different subgroups, but one consolidated billing is prepared by the NMPSIA Third Party Administrator for Enrollment, Eligibility and Billing and remitted to the vendor for either self-insured fees or premiums.
• NMPSIA will receive a claims invoice from the contracted offeror and complete an ACH payment within the parameters of the contract. NMPSIA reserves the right to request detailed data files to support the claims invoice request.

SONM

• Regarding premium/fee billing, SONM prepares a consolidated premium/fee statement that combines all their agencies. SONM bills monthly premium to the individual LPB's, and each state agency premium feeds into the Department of Finance and Administration on a bi-weekly basis, and they submit premium to the Risk Management Division bi-

weekly on their behalf.

• The SoNM will require that invoices from carriers be submitted separately for SoNM and LPB claims and ASO's.

APS

• Regarding premium/fee billing, as indicated in Section 7 and Section 8 of the APS contract template:

− APS will provide Contractor with eligibility/enrollment data on a weekly basis through electronic full file replacement utilizing HIPAA 834 standard format.

− Contractor shall bill APS on a monthly basis for Administrative Services Only (ASO) fees on a per enrolled Member Per Month (PMPM) or per enrolled Employee Per Month (PEPM) basis, as outlined in the Pricing Proposal which was part of the Contractor's response to RFP 24-021CG, Part B and which was agreed upon by APS during contract and implementation negotiations with the awarded vendor/vendors.

− APS cannot pay ASO fees in advance. Therefore, the Contractor must accept payment for ASO fees a month in arrears.

• Regarding funding and payment of APS claims, contractor shall give weekly notice to APS of the amounts required to be transferred to Contractor's Claim Payment Account to fund checks/electronic payments issued during the prior week. APS will appropriately fund the Claims Payment Account by ACH or wire transfer within three (3) APS business days after notification from the Contractor.

• Should APS elect to move to a fully insured contract, premium payment details and timing will be negotiated with the awarded vendor/vendors.

NMRHCA

• Regarding premium/fee billing, NMRHCA bills all retirees and eligible dependents directly. NMRHCA receives administrative invoices for members covered under specific vendors on a monthly basis (per the current billing schedule of the vendors and mutually agreed upon by NMRHCA). Membership is validated through a reconciliation process and payment is made.

• NMRHCA receives claims funding invoices on a weekly/bi-weekly basis dependent on

the claims funding process of each vendor and mutually agreed upon by NMRHCA. NMRHCA requires invoice billing and does not self-bill for medical plans.

• NMRHCA remits payments of invoices per the requested method by our vendors (check, ACH).

9. Scope of Services: 4. The scope of services references the initial effective date for the coverage is July 1, 2024, for all IBAC agencies except APS. However, all materials for each agency seem to indicate open enrollment is for January 1 each year. Should a new vendor be awarded the business, would member coverage go live on July 1, 2024, or January 1, 2025?

All contracts, except with APS plans, will have an effective date of July 1, 2024. APS's effective date is January 1, 2025. Depending on the line of coverage and/or award, an off cycle open enrollment may need to occur or alternatively, an IBAC agency could offer a new plan as of July 1 and accept new potential members until an official open enrollment for January 1 occurs. This decision will be separately provided by each IBAC agency and each line of coverage, as necessary.

10. Please confirm how many total Medicare plans can we offer. Is the maximum 3 or 4?

As stated in The Medicare Advantage Pricing Exhibit, Directions Worksheet:
Plan Design – Please provide fully insured quotes for the following types of plan designs.
a) Current Plan Design. Please provide quotes for fully insured Medicare Advantage products that match current plan designs. (Current plan designs included on NMRHCA's website: https://www.nmrhca.org/wp-content/uploads/2023/04/2023-Summary-of-Benefits_V4.20.23.2-1.pdf). If you are unable to provide exactly the same benefit structure, please quote a plan that is as close as is possible and clearly note the differences.

b) Alternative Plan Designs. Up to two additional Medicare Advantage plan designs may be quoted at the discretion of the offeror based on offeror's knowledge of market trends and benchmarks to other public employee retiree health programs. For example, a plan quote could include a state-wide or national PPO option.

11. Can you confirm we are only quoting fully insured on the plans, claims, members we have in place with our own plan?

Fully insured medical quotes should be based on the plan designs in place today. Each proposer may quote on the coverage and IBAC agency plan(s), per the instructions, they would like to place business with. While the IBAC agencies currently have "slice" offerings (i.e., members choose between mutually exclusive plan options from more than one vendor), there is no requirement that this approach continue. IBAC agencies may award one or more than one offeror for each line of coverage, and the agencies are not required to select the same providers/carriers.

12. Per RFP instructions, a number of files, including questionnaires, are to be uploaded in their original format (i.e., Excel). Since the Excel files are completely locked, bidders will not be able to mark content proprietary or confidentiality. Please confirm it is acceptable for bidders to upload a full pdf version of the entire Proposal (Part A Proposal and/ or Part B Proposal), with proprietary or confidential content redacted.

There are designated areas (colored light-yellow) in every attachment that requires a response for RFP evaluation. Please indicate in the designated area if you consider that response to be proprietary/confidential. For questionnaires specifically, there is a Deviation/Exceptions tab in each questionnaire that Offerors can choose to use in their response to this RFP. The IBAC agencies may or may not accept the deviation/exceptions.

All offeror's responses are subject to public inspection through the IPRA process. Offeror's may choose to, but are not required to, submit a redacted RFP response in addition to their full response submission.

13. Does NMRHCA still require the medical ASO fees be billed on a PMPM basis (versus PEPM)? If so, we will need to decline to quote that entity.

Yes, NMRHCA requires ASO fees be billed on a PMPM basis.

14. Please provide the current contributions for the Medicare members under the NMRHCA group.
Current contribution rates are posted on the agency's website:
• New Mexico Retiree Health Care Authority (NMRHCA) – http://nmrhca.org/
Contributions for NMRHCA participants are subsidized by that agency, with subsidy levels as described in 2.81.11 NMAC and varying based on the retiree's years of credited service and possibly subject to a minimum retiree age.

15. The RFP is requesting original signatures. Is it allowable to provide electronic signatures for the proposal submission and we will provide the originals at the finalist meeting?

Yes. Electronic signatures are acceptable for the proposal submission.

16. Please provide both monthly claims data, monthly enrollment counts and monthly risk scores for both MA and PDP for each of the current vendor MA populations.

Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. No further data/information will be made

available. Given the size of some of the current MAPD plans, risk score information was not made available.

17. Do the MAPD benefits renew on 1/1 and the pricing off cycle?

The contract period for the MAPD benefits commences on July 1. The MAPD plans, per CMS, are all calendar year plans. The Pricing Exhibit for MAPD is requesting quotes for July 1, 2024 – December 31, 2024, and then on a calendar year basis starting in 2025.

18. The pricing grids shows that the lowest membership tier is 20,000 members or less. Is it possible to add additional tiers for smaller thresholds or is 20,000 the lowest allowed by IBAC?

The IBAC does not see an issue with accepting quotes containing smaller enrollment tier thresholds in addition to the quotes specifically requested in the RFP.

19. Please provide full SPDs for the retiree benefits for NMRHCA.

Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. No further data/information will be made available.
Additionally, all plan documents are located on www.nmrhca.org or the microsites listed under the Retiree resources on the website.

20. What is the NMRHCA contribution strategy for Medicare eligible retirees?
Current contribution rates are posted on the agency's website:
• New Mexico Retiree Health Care Authority (NMRHCA) – http://nmrhca.org/
Medical contributions for NMRHCA participants are subsidized by that agency, with subsidy

levels as described in 2.81.11 NMAC and varying based on the retiree's years of credited service and possibly subject to a minimum retiree age.

21. In terms of the general questionnaire, do we have to have all lines answered for Part A, or can we submit responses for the lines of business specific to Part A, and then resubmit the questionnaire with lines of business applicable to Part B with the Part B submission?

If you are submitting responses to both Parts A and B of this RFP, you should submit "RFP#24-021CG_B-Offeror Name-General Questionnaire (all offerors)" with your Part A submission due on 11/17/2023. There is no need to submit the same file a second time with your Part B submission.

If you are only submitting a response to Part B, you should submit "RFP#24-021CG_B-Offeror Name-General Questionnaire (all offerors)" with your submission to Part B due on 11/22/2023.

22. Please confirm NMRHCA will consider an alternative proposal that could save the State additional dollars but provide equal to or better benefits than what is in place today. For example: Will NMRHCA permit bidders to consolidate the two PPO plans into one, ensuring no member has a benefit reduction? Will NMRHCA consider consolidating the number of plans for Medicare-eligible retirees, assuming no member has a benefit reduction?

Per the RFP, RHCA requires the current plan designs to be quoted, however, there is no requirement to remain contracted with multiple medical carriers/administrators and/or offer multiple benefit plans.

Plan design alternatives and pricing impact of consolidating offerings will be considered in

addition to the quotes specifically requested in the RFP.
NMRHCA will evaluate the responses received and determine the most advantageous offeror and approach to control costs to the agency and retirees.

23. Due to the offering companies being different for dental, vision, and Medicare Advantage, please confirm it is acceptable to provide a separate General Questionnaire with our Part A proposal and with our Part B proposal, as some questions will require different responses between the lines of business.

If you are submitting responses to both Parts A and B of this RFP, you should submit "RFP#24-021CG_B-Offeror Name-General Questionnaire (all offerors)" with your Part A submission due on 11/17/2023. There is no need to submit the same file a second time with your Part B submission.
If you are only submitting a response to Part B, you should submit "RFP#24-021CG_B-Offeror Name-General Questionnaire (all offerors)" with your submission to Part B due on 11/22/2023.
As noted in the questionnaire instructions, Offerors are permitted to include a one (1) page attachment to each questionnaire with supplemental information.

24. Please clarify which RFP Priorities apply to fully insured Medicare Advantage offerings.

Refer to page 30 of the RFP for requirements of the Fully Insured Medicare Advantage Plans and page 34 for NMRHCA specific priorities.

25. Please indicate if the MA medical claims include any costs for each of the following:
a. Non-Medicare Covered Fee-for-Service Costs (i.e., private duty nursing, routine vision/dental/hearing/OTC, etc.)
b. Clinical/Quality/Disease Management Program Costs

c. Fitness/Travel Programs

d. IBNR

e. Part B Rx Claims

Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. Claims data was provided by each incumbent. No further data will be made available, please provide your best offer based on the claims data provided.

26. For Group 4, please provide current MA population risk score for both medical and Rx. We prefer risk scores to be provided as monthly averages for the corresponding months of claims data provided. Regarding the provided risk scores, the following information is required:

a. Time period (e.g., calendar year average, recent month, etc.)

b. Estimated or actual mid-year payment and final reconciliation

This information is not available at this time. Offerors should provide their most competitive offer based on the specifications provided in the RFP and related data information provided via the SFT site.

27. Will MAPD quotes only be considered if rate guarantees are offered through the 2028 plan year? Please clarify how price guarantees will impact the evaluation of rates.

Please refer to document RFP#24-021CG_Q - Offeror Name - Medicare Advantage Pricing Exhibits and the Evaluation Criteria section starting on page 37 of the RFP which in combination outlines the cost evaluation. If you are able to provide multi-year premium guarantees, this information can be provided on the applicable tab in the Medicare

Advantage Pricing Exhibits.

28. Please indicate if default enrollment options will remain the same or change for future years.

At this time, the IBAC is requesting proposals based on the current default enrollment options. Please indicate any anticipated impact to your proposal if default enrollment options were to change during the contract period.

29. Regarding Group 4's provided PD claims file, please provide an updated detailed Rx claims file that includes member ID and all unredacted NPI data.

This information is not available at this time. Offerors should provide their most competitive offer based on the specifications provided in the RFP and related data provided via the SFT site.

30. Please provide current Part D risk score. Please note the month or time period of the risk and if it includes mid-year or final payments.

• Please provide the most recent available MMR (monthly membership report).

a. Please indicate whether the claims have been reduced for the following:

b. Pharmaceutical discount in the coverage gap

c. Manufacturer Rebates

d. Catastrophic Reinsurance

e. member cost share

If no to any of the above components, please provide these amounts separately.

• If included, please list any Non-Part D drugs or lifestyle drugs covered on the current Part D plan?

• Are Part B Rx claims included in the claims provided? And if so, are they included in the pharmacy or medical claims data? If not included in medical or

pharmacy data, please provide?

This information is not available at this time. Claims data was provided by each incumbent. Offerors should provide their most competitive offer based on the specifications provided in the RFP and related data information provided via the SFT site.

31. It appears that there may be a separate submission portal for Part A versus Part B … is this correct?

The portal is Vendor Registry. This RFP is comprised of two parts with differing due dates for each.

1. RFP 24-021 Part A: Vision, Dental and EAP proposals;
Due Date and Time for submittals: 11/17/2023@ 3pm local time
2. RFP 24-021 Part B: Self-funded Medial and Medicare proposals and Fully insured active and pre-Medicare Medical proposals
Due Date and Time for submittals: 11/22/2023@ 3pm local time

All proposals for both Part A and Part B must be submitted electronically via electronic bid and RFP system (Vendor Registry) by the date and time specified in the RFP schedule. https://vrapp.vendorregistry.com/Vendor/Register/Index/albuquerque-public-schools-nm-vendor- registration

Offerors understand and agree that technical support may not be readily available the day of and or the hours/minutes prior to due date and time. Offerors also understand and agree that internet access, browsers, and operating systems are not supported by the District and/or its agents. Offerors are strongly encouraged to review, create, and submit all electronic RFP responses several days in advance of the due date and time.

32. Are both proposals to be submitted through Vendor Registry, but on different portals?

The portal is Vendor Registry. This RFP is comprised of two parts with differing due dates

for each.

1. RFP 24-021 Part A: Vision, Dental and EAP proposals;

- Due Date and Time for submittals: 11/17/2023@ 3pm local time

2. RFP 24-021 Part B: Self-funded Medial and Medicare proposals and Fully insured active and pre-Medicare Medical proposals;

- Due Date and Time for submittals: 11/22/2023@ 3pm local time

All proposals for both Part A and Part B must be submitted electronically via electronic bid and RFP system (Vendor Registry) by the date and time specified in the RFP schedule. https://vrapp.vendorregistry.com/Vendor/Register/Index/albuquerque-public-schools-nm-vendor- registration

Offerors understand and agree that technical support may not be readily available the day of and or the hours/minutes prior to due date and time. Offerors also understand and agree that internet access, browsers, and operating systems are not supported by the District and/or its agents. Offerors are strongly encouraged to review, create, and submit all electronic RFP responses several days in advance of the due date and time.

33. Would IBAC consider receiving an online link to the requested provider lists in lieu of the MS Excel file as this could be a very large file considering our New Mexico providers as well as our national wrap network providers?

This is acceptable as long as the online link is downloadable in Excel or CSV format.

34. How should we respond to questions where we are asked to provide an explanation and only a drop-down version of yes/no is provided? Can we provide an exhibit to provide clarifying details?

Per the Vendor Instructions tab in each Questionnaire, offerors are permitted in total a one (1) page attachment (letter (8.5"x11") sized, 1-sided, 12-point font) per questionnaire to

include any necessary additional information relating to the questions included in that questionnaire. One-page responses must be done and submitted in Word format. Anything more than the permitted one page may be excluded during the evaluation process. Please label these attachments according to the naming directions in each questionnaire's Vendor Instructions tab and include the attachment(s) in your response to this RFP.

35. Please clarify the number of references required for this RFP. Is the requirement to provide seven references for each quoted line of business or seven references total for both Parts A and B?

The seven requested organizational references should be businesses or organizations for which the Offeror has provided similar services to those it is proposing in its RFP response. For an Offeror proposing for multiple coverage lines, please include seven relevant organizational references for each coverage line. The IBAC recognizes that this may result in the same reference being included multiple times (i.e., once for each applicable coverage line).

36. As an in-force carrier with the IBAC entities, is providing redlined sample contracts required, or is it preferred to provide current contract copies along with a response to indicate that we have and will continue to work with each agency with respect to acceptable contract language?

Redline edits to draft contracts are a required item to be included with all proposals, including those from incumbent vendors.

37. Please provide all disruption files with ZIP codes. New provider disruption files containing this information will need to be provided for us to run a full provider disruption analysis.

Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. No further data/disruption file will be made available. Please use the repricing files to specify in and out of network providers.

38. Specific to question 4.14 in the General Questionnaire, "Does your system support on-line, real-time Electronic Data Interface (EDI) eligibility and claim status inquiries?" please clarify if this is regarding information accessible to the member, client, or our providers.

Question 4.14 is specific to information accessible to the IBAC agencies or their designee (such as a third party administrator or consultant).

39. Specific to question 2.36 in the Active & Pre-Medicare Questionnaire, "Confirm you will cooperate with any third party claims integrity review service that any IBAC agency contracts with to perform these reviews, at no additional cost to each IBAC agency (so long as the selected vendor is not a competitor or involved in any legal proceedings with your organization)." is this reference to an audit or an ongoing claims activity review vendor?

There is discussion at the New Mexico legislature to require on-going claims integrity reviews of IBAC agency claims. Question 2.36 is related to vendors who supply that service.

40. What is the intent of question 2.24 in the General Questionnaire, When an audit is conducted and an error is identified, what are the steps to remedy the issue? It appears question 2.24 refers to Payment Integrity, yet the preceding question 2.23 "Right to Audit: The IBAC reserves the right to review and audit the vendors' files and financial accounting data to assure that claims subject to each proposed

coverage are evaluated in accordance with the plan provisions. Additionally, the vendor agrees to allow for no less than one claim audit per year at no additional cost to the IBAC using the auditor of the IBAC's choice (so long as the auditor is not a competitor or involved in any legal proceedings with the vendor). The vendor will cooperate with any outside auditor the IBAC agencies contract with to perform the audit. This provision shall survive the termination of the agreement between the parties for a period of 5 years." appears to be related to External Customer Audit.
Please confirm if these questions are related specifically to the recovery of those errors identified as the result of an external medical claims audit, or are you asking for the recovery process for overpayments identified by BCBSNM through internal quality/payment integrity reviews?

Question 2.23 is asking for confirmation that your organization agrees to the Right to Audit provision.
Question 2.24 is inquiring about the steps your organization takes to remedy (remedy definition: set right (an undesirable situation)) when an error is found during an audit of the firm.
Question 2.25 is asking for confirmation that your organization will reimburse the Agencies for any payment/processing errors identified through an audit.

41. (Medicare) Do the 280 persons under age 65 have MDCR parts A&B?

All Medicare eligible retirees and dependents are required to enroll into Medicare parts A&B to be eligible to enroll into a RHCA MA or Supplement plan.

42. (Medicare) Please confirm the Medicare Retiree effective date is 1/1/25.

The contract period for both the Medicare Advantage and Medicare Supplement commences on July 1. The MAPD plans, per CMS, are all calendar year plans. The Pricing

Exhibit for MAPD is requesting quotes for July 1, 2024 – December 31, 2024, and then on a calendar year basis starting in 2025.

43. (Medicare) Please provide PBM commercial ASO, and ESI Part D formulary disruption analysis.

The prescription drug program will not be part of this IBAC RFP process (with the exception of the fully insured Medicare Advantage plans). Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. No further data/disruption file will be made available.

44. (Medicare) Please provide eligibility language for MA plans. Are there any differences in eligibility by carrier?

NMRHCA Medicare Eligibility Guidelines are included in the Summary of Benefits Booklet posted on the agency's website:
• New Mexico Retiree Health Care Authority (NMRHCA) – http://nmrhca.org/

45. (Medicare) Please provide Part D claim information from all PDP plan designs for disruption reporting.

The prescription drug program will not be part of this IBAC RFP process (with the exception of the fully insured Medicare Advantage plans). Census files, claims workbooks, and other historical experience data have been made available through Segal's Secure File Transfer System to all offerors who have a current Non-Disclosure Agreement on file with Segal. No further data/disruption file will be made available.

46. (Medicare) If a Medicare eligible individual fails to enroll, is there an auto enrollment

strategy, and how is the made for the auto-enroll carrier? Lowest cost option?

Currently RHCA has a default strategy in place for eligible retirees or dependents enrolled in pre-65 non-Medicare plans becoming Medicare eligible. This occurs if an eligible retiree or dependent does not enroll in a Medicare Advantage or Supplement plan upon becoming eligible. The current default strategy enables eligible retirees and dependents to continue utilizing the network of providers they utilized while being enrolled in one of the pre-65 non-Medicare plans. They are defaulted into the national MA carrier utilizing the corresponding network or providers in NM.

47. (Medicare) What are contribution changes prospectively?

NMRHCA contribution changes to the pre-Medicare and Medicare supplement plans are typically determined each year at the Annual Meeting of the Board of Directors. Contributions for NMRHCA participants are subsidized by that agency, with subsidy levels as described in 2.81.11 NMAC and varying based on the retiree's years of credited service and possibly subject to a minimum retiree age. No specific changes are contemplated at this time.

ACKNOWLEDGE ADDENDUM WITH SUBMITTED PROPOSAL:
Addenda not signed and returned may consider the RFP non-responsive and may be rejected.

_____
COMPANY/FIRM NAME

_____
SIGNATURE

_____
DATE