|  |
| --- |
| **2020 RFQ Insurance Broker****(Employee Health Benefits)** |
| A Proposal Submitted in Response to  C2 Global Professional Services, LLC  Response to the  2020 Request for Qualifications  for  Insurance Broker (Employee Health Benefits)  Submitted By:  Full Legal Name of Respondent: Click here to enter text.  Date of Proposal Submission: Click here to enter a date. |
|  |
| **QUALIFICATIONS TO PROVIDE SERVICES FOR**:  Voluntary Employee Benefits  Medical Insurance and Prescription Coverage  Dental Insurance  Vision Care  Group Life and AD&D (employer sponsored coverage plus voluntary employee options)  Disability Insurance (Short-Term and Long-Term)  Supplemental benefits (Voluntary)  Flexible Spending Account Plans (Dependent Care and Health Care plans) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ATTACHMENT A: CERTIFICATION BY PROPOSER of Legal and Signatory Authority (including HUB statement) for 2020 RFQ INSURANCE BROKER (EMPLOYEE HEALTH BENEFITS)** | | | | |
| **I. IDENTIFICATION OF RESPONDENT (All fields are required)** | | | | |
| Name of Individual Responding: Click here to enter text. | | | | |
| Name of Firm (if applicable): Click here to enter text. | | | | |
| Mailing Address: Click here to enter text. | | | E-mail: Click here to enter text. | |
| City: Click here to enter text. | | State: | Zip Code: Click here to enter text. | |
| Telephone: Click here to enter text. | | | Fax: Click here to enter text. | |
| How many years has your firm been providing same/similar services? Click here to enter text. | | | | |
| How many years of direct knowledge working with Contractors in a workforce environment? Click here to enter text. | | | | |
| How many years of experience do you have working with for-profits? Click here to enter text. | | | | |
| NOTE: C2 GPS ensures that small, minority, disadvantaged, and women’s businesses are utilized as sources for acquisitions whenever possible. Auxiliary aids and services are available upon request to individuals with disabilities. Please check if your firm is a historically underutilized (disadvantaged) business (HUB), as defined by the Texas Government Code 407.101 or other state.  Is your firm registered with a state entity as a Historically Underutilized Business (HUB)? Click here to enter text. If HUB please attach certification. | | | | |
| Provide a brief description of your organization legal status, size, and whether it is local, regional or national in operation: Click here to enter text. | | | | |
| **II. DESCRIPTION OF SERVICES PROVIDED** | | | | |
| What types of reporting tools will be used? Click here to enter text. | | | | |
| When can you/will you be available to perform services? | | | | |
| **III. SIGNATURE** | | | | |
| Respondent certifies that each attachment to this Statement of Qualifications has been completed and is submitted as an integral part to this Statement.  I certify that I am authorized to submit this Statement on behalf of the above named organization. If any information changes significantly, C2 GPS will be notified. I certify that the contents of this document are true and correct. | | | | |  |
|  | | |  | | |
| Signature of Respondent | | | Date Proposal Form Submitted | | |
| NOTE: The deadline for responses from the RFP refer to the receipt of hard copy proposals. Responses received after the deadline will not be considered. | | | | |  |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT B: CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS** | | |
| **This certification is required by the Federal Regulations Implementing Executive Order 12549, Debarment and Suspension, 45 CFR Part 93, Government-wide Debarment and Suspension, for the Department of Agriculture (7 CFR Part 3017), Department of Labor (29 CFR Part 98), Department of Education (34 CFR Parts 85, 668, 682), Department of Health and Human Services (45 CFR Part 76).**  The undersigned certifies, to the best of his or her knowledge and belief, that both it and its principals:   1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency; 2. Have not within a three-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or contract under a public transaction, violation of federal or State antitrust statues or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property; 3. Are not presently indicated for or otherwise criminally or civilly charged by a government entity with commission of any of the offense enumerated in Paragraph (2) of this certification; and, 4. Have not within a three-year period preceding this contract had one or more public transactions terminated for cause or default.   Where the prospective recipient of federal assistance funds is unable to certify to any of the statements in this certification, such prospective recipient shall attach an explanation to this certification form. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |  |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT C: CERTIFICATION REGARDING CONFLICT OF INTEREST** | | |
| By signature of this bid proposal, Proposer covenants and affirms that:  No manager, employee or paid consultant of the Proposer is an employee of Workforce Solutions, or an employee of C2 GPS;  No manager, employee or paid consultant of the Proposer is an employee of Workforce Solutions, or an employee of C2 GPS;  No manager or paid consultant of the Proposer an employee of Workforce Solutions, or an employee of C2 GPS;  No employee of Workforce Solutions, or an employee of C2 GPS is a manager or paid consultant of the Proposer;  No employee of Workforce Solutions, or an employee of C2 GPS receives compensation from Proposer for lobbying activities as defined in Chapter 305 of the Texas Government Code;  Proposer has disclosed within the Bid any interest, fact or circumstance which does or may present a potential conflict of interest;  Should Proposer fail to abide by the foregoing covenants and affirmations regarding conflict of interest, Proposer shall not be entitled to the recovery of any costs or expenses incurred in relation to any contract with C2 GPS and shall immediately refund to C2 GPS any fees or expenses that may have been paid under the contract and shall further be liable for any costs incurred or damages sustained by C2 GPS relating to that contract. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ATTACHMENT D: DISCLOSURE OF INTERESTS** | | | | |
| It is the fiscal policy of C2 GPS that all persons or firms seeking to do business with C2 GPS to provide the following information**. Every question must be answered. *If the question is not applicable, answer with “NA”.*** | | | | |
| Company Name: | | | | |
| Federal ID#: | | | | |
| Mailing Address: | | | E-mail: | |
| City: | | State: | Zip Code: | |
| Telephone: | | | Fax: | |
| Firm is:  Corporation  Partnership  Sole Owner  Association  Corporation  Other | | | | |
| 1. State the name of each “**non-managerial employee**” of having an “ownership interest” constituting 10% or more of the ownership in the above name “firm.”  Name: Job Title: | | | | |
| 2. State the names of each “**managerial employee**” of C2 GPS having an “ownership interest” constituting 10% or more of the ownership in the above name “firm.”?  Name: Job Title: | | | | |
| 3. Other  Name: Job Title: | | | | |
| Name of Organization/Firm: | | | | |
|  | | |  | | |
| Signature of Authorized Representative | | | Date | | |
| Print Name and Title of Authorized Representative: | | | | |  |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT E: CERTIFICATION REGARDING DRUG-FREE WORKPLACE** | | |
| *This certification is required by the Federal Regulations Implementing Sections 5151-5160 of the Drug-Free Workplace Act, 41 U.S.C. 701, for the Department of Agriculture (7 CFR Part 3017),* *Department of Labor (29 CFR Part 98), Department of Education (34 CFR Parts 85, 668 and 682), Department of Health and Human Services (45 CFR Part 76).*  The undersigned subcontractor certifies it will provide a drug-free workplace by:  Publishing a policy statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace and specifying the consequences of any such action by an employee;  Establishing an ongoing drug-free awareness program to inform employees of the dangers of drug abuse in the workplace, the subcontractor’s policy of maintaining a drug-free workplace, the availability of counseling, rehabilitation and employee assistance programs, and the penalties that may be imposed on employees for drug violations in the workplace;  Providing each employee with a copy of the subcontractor’s policy statement;  Notifying the employees in the subcontractor’s policy statement that as a condition of employment under this subcontract, employees shall abide by the terms of the policy statement and notifying the subcontractor in writing within five days after any conviction for a violation by the employee of a criminal drug abuse statue in the workplace;  Notifying the C2 GPS within ten (10) days of the subcontractor’s receipt of a notice of a conviction of any employee; and,  Taking appropriate personnel action against an employee convicted of violating a criminal drug statute or requires such employee to participate in a drug abuse assistance or rehabilitation program. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT F: CERTIFICATION REGARDING LOBBYING** | | |
| *This certification is required by the Federal Regulations Implementing Section 1352 of the Program Fraud and Civil Remedies Act, Title 31 U.S. Code for the Department of Agriculture (7 CFR Part 3018), Department of Labor (29 CFR Part 93), Department of Education (34 CFR Part 82), Department of Health and Human Services (45 CFR Part 93).*  The undersigned certifies to the best of his/her knowledge and belief, that:   1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of Congress, or an employee or a Member of Congress in connection with the awarding of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of a federal contract, grant, loan, or cooperative agreement. 2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, and or cooperative agreement, the undersigned shall complete and submit Standard Form – LLL, “Disclosure Form to Report Lobbying”, in accordance with the instructions. 3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT G: CERTIFICATION REGARDING TEXAS CORPORATE FRANCHISE TAX** | | |
| *Pursuant to Article 2.45, Texas Business Corporation Act, state agencies may not contract with for-profit corporations that are delinquent in making state franchise tax payments. The following certification that the entity entering into this subcontract is current in its franchise taxes or is not subject to the payment of franchise taxes to the State of Texas must be signed by the individual authorized to sign the subcontract for the subcontracting entity.*  The undersigned authorized representative of the entity subcontracting herein certifies that the following indicated statement is true and correct and that the undersigned understands making a false statement is a material breach of subcontract and is grounds for subcontract cancellation.  Indicate the certification that applies to your subcontracting entity:  The subcontracting entity is a for-profit corporation and certifies that it is not delinquent in its franchise tax payments to the State of Texas.  The subcontracting entity is a non-profit corporation or is otherwise not subject to payment of franchise taxes to the State of Texas. | | |
| Name of Organization/Firm: | | |
| Type of Business (if not corporation):  Sole Proprietor  Partnership  Other | | |
| I.R.S. Tax Number: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT H: STATE ASSESSMENT CERTIFICATION** | | |
| The authorized representative of the corporation contracting herein by executing this contract certifies that the following indicated statement is true and correct and that the undersigned understands making a false statement is a material breach of contract and is grounds for contract cancellation.  The corporation certifies that:  It is current in Unemployment Insurance taxes, Payday and Child Labor law monetary obligations, and Proprietary School fees and assessments payable to the State of Texas or to the State of Florida  It has no outstanding Unemployment Insurance overpayment balance payable to the State of Texas or to the State of Florida. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT I: EQUAL OPPORTUNITY AND NONDISCRIMINATION** | | |
| **EQUAL OPPORTUNITY AND NONDISCRIMIANTION**  Click here to enter Company Name promotes employment opportunity through a progressive program designed to provide equal opportunity without regard to race, color, sex, religion, national origin, age, disability, or political affiliation or belief. Additionally, discrimination is prohibited against any beneficiary of programs funded under Title I Section 188 of the Workforce Innovation and Opportunity Act of 2014, on the basis of the beneficiary’s citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his/her participation in any WIOA Title I financially assisted program or activity. conforms to all applicable federal and state laws, rules, guidelines, regulations, and provides equal employment opportunity in all employment and employee relations.  **EEO Laws, Rules, Guidelines, Regulations**  Click here to enter Company Name provides equal opportunities consistent with applicable federal and state laws, rules, guidelines, regulations, and executive orders (29 CFR 38.25). Such regulations include:   * Section 188 of the Workforce Innovation and Opportunity Act (WIOA), which prohibits discrimination against all individuals in the United States on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief, or against beneficiaries on the basis of either citizenship status or participation in any WIOA Title I-financially assisted program or activity; * Title VI of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color and national origin.; and * Title VII of the Civil Right Act of 1964, as amended, and its implementing regulations at 29 CFR Part 38 which prohibits discrimination based on race, color, religion, sex or national origin in any term, condition or privilege of employment. * Sections 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination against qualified individuals with disabilities; and * The Age Discrimination in Employment Act of 1967, as amended, which prohibits discrimination on the basis of age (*i.e*., individuals 40 years of age and older); and * The Age Discrimination Act of 1975, as amended, which prohibits discrimination against qualified individuals with disabilities; * Title IX of the Education Amendments of 1972, as amended, which prohibits discrimination on the basis of sex under any education program or activity receiving Federal financial assistance; and * Americans with Disabilities Act of 1990, as amended; which prohibits discrimination against qualified individuals with disabilities; and * The anti-discrimination provisions of the Immigration and Nationality Act, as amended; and * Equal Pay Act of 1963, as amended, which requires equal pay for men and women performing equal work; and * Pregnancy Discrimination Act of 1978, which prohibits discrimination against pregnant women; and * Texas Commission on Human Rights Act, as amended, which prohibits discrimination in employment based on race, color, handicap, religion, sex, national origin, or age (40-70).   This assurance applies to the applicant’s operation of the WIOA Title I-financially assisted program or activity, and out of the WIOA Title I – financially assisted program or activity. The grant applicant understands that the United States has the right to seek judicial enforcement of this assurance. | | |
| Click here to enter Company Name is committed to promoting equal employment opportunity through a progressive program designed to provide equal opportunity without regard to race, color, religion, sex, (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief. Click here to enter Company Name takes positive steps to eliminate any systematic discrimination from personnel practices. Click here to enter Company Name recruits, hires, trains, and promotes into all job levels the most qualified persons without regard to race, color, religion, sex, national origin, age, sexual orientation, disability, or political affiliation or belief.  Staff at all levels is responsible for active program support and personal leadership in establishing, maintaining, and carrying out an effective equal employment opportunity program. | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |
| --- |
| **ATTACHMENT J: REFERENCES / PAST EXPERIENCES SHEET** |
| Submit a minimum of three (3) references of active clients. The active clients must be current customers at the time of response submission and must be three distinct customers. If your firm currently has or previously had a contract with C2 GPS, do not include it as one of the three references. |
| Failure to provide and include the following information with your response by the submission date of the bid may result in disqualification from further consideration for an award resulting from this solicitation. Each reference will be contacted for evaluation purposes. Any reference that does not respond in the allotted time provided by the C2 GPS will result in a score of zero. |
| **Reference 1**  Click here to enter Company Name.  Click here to enter Contact Name.  Click here to enter Address, City, State, Zip.  Click here to enter Phone Number.  Click here to enter Fax number  Click here to enter E-mail Address.  **Types of Services provided**: Click here to enter text.  **Contract Term (how many years provided services (To/From dates)**: Click here to enter text. |
| **Reference 2**  Click here to enter Company Name.  Click here to enter Contact Name.  Click here to enter Address, City, State, Zip.  Click here to enter Phone Number.  Click here to enter Fax number  Click here to enter E-mail Address.  **Types of Services provided**: Click here to enter text.  **Contract Term (how many years provided services (To/From dates)**: Click here to enter text. |
| **Reference 3**  Click here to enter Company Name.  Click here to enter Contact Name.  Click here to enter Address, City, State, Zip.  Click here to enter Phone Number.  Click here to enter Fax number  Click here to enter E-mail Address.  **Types of Services provided**: Click here to enter text.  **Contract Term (how many years provided services (To/From dates)**: Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **ATTACHMENT K: Cost Reasonableness & Value Added Services (10 points)** | | |
| This evaluation factor relates to the cost reasonableness of proposed services. All associated costs for doing business regarding proposed services should be included in the proposed budget including but not limited to:   1. **Costs**: Please indicate if your fees will be paid directly from C2 GPS or if your fees will be obtained from the insurance companies. Please explain: Click here to enter text. 2. Itemize all applicable **fees** including one-time fees (*i.e*., set up) and recurring including but not limited to:   Administrative Fees: Click here to enter text.  Marketing Fees: Click here to enter text.  Service Fees: Click here to enter text.  Other Fees: Click here to enter text.  Base Commissions: The commission rate is the percentage of annual premium excluding taxes and fees: Click here to enter text.  Policy Commissions: Click here to enter text.  Other Commissions: Click here to enter text.  Non-monetary Compensation: Click here to enter text.  Supplemental Compensation: Click here to enter text.  Contingent Compensation is contingent upon performance factors such as growth, profit, volume or retention: Click here to enter text.  Other Compensation: | | |
| Name of Organization/Firm: | | |
|  |  | | |
| Signature of Authorized Representative | Date | | |
| Print Name and Title of Authorized Representative: | | |

|  |
| --- |
| **ATTACHMENT L: Additional Insurance Broker Documentation** |
| A Proposer is required to be licensed:  1.  State of Texas / Florida License  2.  Provide any other relevant documentation showing qualifications  Include supporting documentation *after* **Attachment L** in the order listed above. |