## FORM 4. COST PROPOSAL FORM

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| Proposer Name: | Address: |

1. **COST PROPOSAL FOR: SCVTA - ATU, Local 265 Pension Plan Actuarial Services**

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| **FIRMED FIXED PRICING** | **Optional Years** |
| **Preparation of Actuarial Valuation Reports\*\*** | **1st Year** | **2nd Year** | **3rd Year** | **4th Year** | **5th Year** | **6th Year** | **7th Year** |
| Delivered no later than April 15 |  |  |  |  |  |  |  |
| Less 25% if delivered after April 15 |  |  |  |  |  |  |  |
| Experience Study (if requested) |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |
| **Preparation of GASB 67/68 Reports** | **1st Year** | **2nd Year** | **3rd Year** | **4th Year** | **5th Year** | **6th Year** | **7th Year** |
| Delivered no later than August 31 |  |  |  |  |  |  |  |
| Less 25% if delivered after August 31 |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |
| **Preparation of Benefit Determination (Estimate)** | **1st Year** | **2nd Year** | **3rd Year** | **4th Year** | **5th Year** | **6th Year** | **7th Year** |
| Delivered within 30 days |  |  |  |  |  |  |  |
| Less 25% if delivered after 30 days |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |
| **Preparation of Benefit Determinations (Final)** | **1st Year** | **2nd Year** | **3rd Year** | **4th Year** | **5th Year** | **6th Year** | **7th Year** |
| Delivered within 30 days |  |  |  |  |  |  |  |
| Less 25% if delivered after 30 days |  |  |  |  |  |  |  |
| Less 50% if previous calculations done for the same individual within the past 12 months |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |

**\*\*Please specify the fixed price for each type of valuation report.**

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| **Classification** | **Direct Labor Rate** | **Overhead Rate** | **Profit (%)** | **Fully Burdened Rate** |
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1. **COST PROPOSAL FOR: Spousal Medical Trust Fund and Retiree Dental/Vision Trust**

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| **FIRM FIXED PRICING** | **Optional Years** |
| **Preparation of Valuations** | **1st Year** | **2nd Year** | **3rd Year** | **4th Year** | **5th Year** | **6th Year** | **7th Year** |
| Spouse Medical Fund |  |  |  |  |  |  |  |
| Retiree Vision and Dental |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |

**\*\*Please specify the fixed price for each type of valuation report.**

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| **Classification** | **Direct Labor Rate** | **Overhead Rate** | **Profit (%)** | **Fully Burdened Rate** |
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| Firm Name: |
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| Name | Title |
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| Signature | Date |