

REQUEST FOR GROUP PROPOSAL

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Type of Business: _____ SIC Code: _____

Contact: _____ Contact Phone: _____

E-mail: _____

Requested Effective Date: _____ Renewal Date: _____

GROUP INFORMATION

Total Number of Employees (17.5 Hours per week): _____ Out of State Employees: _____

Employer Contribution: Employee _____% Dependents _____%

Current Medical Carrier: _____ Employee Rate: _____

Current Dental Carrier: _____ Employee Rate: _____

BENEFIT PLAN SELECTION

<input type="checkbox"/> HEALTH	QUOTE <input type="checkbox"/> ALL	DEDUCTIBLE <input type="checkbox"/> 0 <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 2000+		
<input type="checkbox"/> DENTAL	QUOTE <input type="checkbox"/> ALL	PREVENTATIVE <input type="checkbox"/> 100% <input type="checkbox"/> 80%	BASIC <input type="checkbox"/> 80% <input type="checkbox"/> 50%	BENEFIT AMOUNT <input type="checkbox"/> 1000 <input type="checkbox"/> 1500+
<input type="checkbox"/> PRESCRIPTIONS	QUOTE <input type="checkbox"/> ALL	GENERIC COPAY <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> 50%	BRANDED COPAY <input type="checkbox"/> \$20 <input type="checkbox"/> \$40 <input type="checkbox"/> 50%	DEDUCTIBLE <input type="checkbox"/> 100% <input type="checkbox"/> 80%
<input type="checkbox"/> ALTERNATIVE CARE	QUOTE <input type="checkbox"/> ALL	<input type="checkbox"/> NATUROPATH	<input type="checkbox"/> NATUROPATH	<input type="checkbox"/> ACUPUNCTURE
<input type="checkbox"/> VISION	<input type="checkbox"/> TERM LIFE	<input type="checkbox"/> WHOLE LIFE		<input type="checkbox"/> DISABILITY
<input type="checkbox"/> LONG TERM CARE	SUPPLEMENTAL <input type="checkbox"/> CANCER		SUPPLEMENTAL <input type="checkbox"/> ACCIDENT	

COMMENTS

