

REQUEST FOR PROPOSAL FORM

Deadline Date:

Company Name:

Today's Date:

Address:

Phone Number:

City:

State:

Zip:

Effective Date:

GROUP STATISTICS & UNDERWRITING INFORMATION

Years in Business:

SIC Code/Nature of Business:

of Full-Time Employees in Firm: # of Related Employees Enrolling:

Office Locations to be Included (City, State, Zip):

Employer Contribution for Employee Premium: %

Employers Contribution for Dependent Premium: %

Dependent Premium:

of Medical Carriers in Last 3 Years:

BENEFITS, PLAN TYPE & FEATURES REQUESTED

PLAN TYPE	HEALTH BENEFITS	DENTAL BENEFITS
<input type="checkbox"/> Medical <input type="checkbox"/> w/Maternity <input type="checkbox"/> Dental <input type="checkbox"/> w/Orthodontia <input type="checkbox"/> Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Long Term Care <input type="checkbox"/> Vision <input type="checkbox"/> 401(k) <input type="checkbox"/> Employee Paid Life <input type="checkbox"/> Employee Paid Disability <input type="checkbox"/> Employee Paid Vision	<input type="checkbox"/> Dual Option HMO/PPO <input type="checkbox"/> Dual Option HMO/POS <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <p style="text-align: center;">Deductible</p> <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 750 <input type="checkbox"/> Other: <p style="text-align: center;">PPO Coinsurance</p> <input type="checkbox"/> 90/70 <input type="checkbox"/> 80/60 <input type="checkbox"/> 80/70 <input type="checkbox"/> Other: <p style="text-align: center;">Out-of-Pocket \$ Maximum</p> <input type="checkbox"/> 500 <input type="checkbox"/> 750 <input type="checkbox"/> 1,000 <input type="checkbox"/> 1,500 <input type="checkbox"/> Other:	<p style="text-align: center;">Deductible</p> <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> Other: <p style="text-align: center;">Coinsurance</p> Prev. <input type="checkbox"/> 100% <input type="checkbox"/> Other: Basic <input type="checkbox"/> 80% <input type="checkbox"/> Other: Major <input type="checkbox"/> 50% <input type="checkbox"/> Other: Ortho <input type="checkbox"/> 50% <p style="text-align: center;">Annual \$ Maximum</p> <input type="checkbox"/> 1,000 <input type="checkbox"/> 1,500 <input type="checkbox"/> Other: <p style="text-align: center;">Ortho \$ Maximum</p> <input type="checkbox"/> 1,000 <input type="checkbox"/> 1,500 <input type="checkbox"/> Other:
LIFE BENEFITS	LONG TERM DISABILITY	SHORT TERM DISABILITY
<input type="checkbox"/> Flat Amount: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x Salary to Max of:	<p style="text-align: center;">Benefit Percentage</p> <input type="checkbox"/> 60 <input type="checkbox"/> 66-2/3 <input type="checkbox"/> Other: <p style="text-align: center;">Elimination Period (Days)</p> <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> Other: <p style="text-align: center;">Monthly \$ Maximum</p> <input type="checkbox"/> 5K <input type="checkbox"/> 10K <input type="checkbox"/> Other: <p style="text-align: center;">Own Occupation</p> <input type="checkbox"/> 2Yr <input type="checkbox"/> To 65 <input type="checkbox"/> Other:	<p style="text-align: center;">Benefit Percentage</p> <input type="checkbox"/> 60 <input type="checkbox"/> 66-2/3 <input type="checkbox"/> Other: <p style="text-align: center;">Elimination Period (Days)</p> <input type="checkbox"/> 7 <input type="checkbox"/> 14 <input type="checkbox"/> Other: <p style="text-align: center;">Weekly \$ Maximum</p> <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> Other: <p style="text-align: center;">Benefit Period (Weeks)</p> <input type="checkbox"/> 11 <input type="checkbox"/> 13 <input type="checkbox"/> Other:

IMPORTANT NOTES:

RETURN TO: BENEFITSPECIALISTS, INC., 820 Gessner, Suite 1275, Houston, TX 77024
Phone: 713.BENEFIT (236.3348) Fax: 713.461.4053

GROUP PROPOSAL REQUEST FORM

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BY PROVIDING FULL DETAILS BELOW WE ARE ABLE TO BETTER SERVE YOU AND DELIVER THE LOWEST POSSIBLE RATES!

1. Do you currently have a GROUP PLAN : (IF YES, PLEASE INCLUDE A COPY OF YOUR MOST RECENT PREMIUM BILLING STATEMENT) Medical Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Long Term Disability Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Life/AD&D Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. To the best of your knowledge, are any employees or dependents currently disabled, pregnant, hospitalized or being treated for a serious illness? (If yes, please give details below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Will all full-time employees be covered by the plan? (If no, please give details below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are there certain physicians or hospitals that you would like to have in your PPO or HMO network? (If yes, please attach a list of the hospitals and physicians.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GIVE DETAILS TO "YES" RESPONSES BELOW

NUMBER:

DETAILS:

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