26+ Proposal Request

Today's Date:

Group Name:	Group Street Address/City/State/Zip		County:
Agent Name:	Agent E-mail Address:	Marketing Representative:	
Agent Phone:	Agent Fax:	Deadline for Quote:	

☐ **Small Group (26-50 eligible employees)**
☐ **Large Group (51+ eligible employees)**

Coverages Requested: ☐ **Medical** ☐ **Dental**
Special Funding Requests (for groups with 100+ only) ☐ **Retro** ☐ **ASO**

Effective Date of Quote:

An *eligible employee* is an *employee or owner* that works a regular schedule of 17.5 hours or more per week. *Eligible employee* does not include employees who work on a temporary, seasonal, or substitute basis. The total number of *eligible employees* may be different than the actual number of employees eligible for coverage if the plan's hourly requirement is different than 17.5 hours.

Total # active employees on average during the previous *CALENDAR* year:	
Total # of Eligible employees (based on the eligible employee definition above):	
Total currently meeting group's eligibility requirements: class, hours, probationary period	
Total Number Waiving: WITH Other GROUP Coverage: ______ WITHOUT Other GROUP Coverage: ______	-
Subtotal:	
Probationary Employees:	+
COBRA:	+
Retirees:	+
Total Enrolling:	=

Notes:

Enrolling Out-Of-State Employees—Total:

#Emps	City, State or Zip

Required Information for Underwriting

☐ **Group Profile Form**; If we do not receive this form, we cannot issue a quote.

☐ **Employer Contribution**: Employee Premium: ________________ Dependent Premium: ___________________

☐ **Industry/SIC Code**: ____

☐ **Medical Carrier:** ________________________________ ☐ **Medical Renewal Date**: ______________________

☐ **Medical Plan Design**: ____

☐ **Rx Plan Design/Other Optional Benefits:** ____

☐ **Current Medical/Rx Rates: EE:** ______________ **ES:** _____________ **EF:** _____________ **EC:** _____________

☐ **Renewal Medical/Rx Rates: EE:** _____________ **ES:** _____________ **EF:** _____________ **EC:** _____________

☐ If off-renewal, reason: ____

☐ **Dental Carrier:** _________________________________ ☐ **Dental Renewal Date:** ______________________

☐ **Dental Plan Design:** ____

☐ **Current Dental Rates: EE:** _______________ **ES:** _______________ **EF:** ______________ **EC:** _____________

☐ **Renewal Dental Rates: EE:** _______________ **ES:** ______________ **EF:** _____________ **EC**: _____________

☐ If off-renewal, reason: ____

☐ **Number of insurance companies in the last five years?** ________ **List companies/effective dates:**

____ ____
____ ____

☐ **Claims Experience & Large Claims Report** ☐ **MEDICAL** ☐ **DENTAL**
(REQUIRED FOR ALL 100+ GROUPS AND ALL LARGE SELF-FUNDED GROUPS)

For Internal Use Only:

Date ASD Received:	**Client #:**	**Proposal #**	**Keyed by:**	**Date Out:**