

Proposal Request (51+) Today's Date: _____

Group Name:	Group Street Address/City/State/Zip	County:
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Agent Name:	Agent E-mail Address:	Marketing Representative:
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Agent Phone:	Agent Fax:	Deadline for Quote:
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<input type="checkbox"/> Small Group (26-50 eligible employees) <input type="checkbox"/> Large Group (51+ eligible employees)	Coverages Requested: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Special Funding Requests (for groups with 100+ only) <input type="checkbox"/> Retro <input type="checkbox"/> ASO	Effective Date of Quote: _____
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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 <i>CALENDAR</i> 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:	Med.	Dent.
WITH Other GROUP Coverage: _____		
WITHOUT Other GROUP Coverage: _____		
Subtotal:		
Probationary Employees:	+	
COBRA:	+	
Retirees:	+	
Total Enrolling:	=	

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)

Notes:

Enrolling Out-Of-State Employees—Total:	
#Emps	City, State or Zip

For Internal Use Only:

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