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| Producer/Agency Name: | | Producer/Agency #: | | | | | | |
| Producer/Agency Phone #: | | Send proposal to the following email: | | | | | | |
| Business Name (and DBA, if applicable): | | Requested Effective Date | | | | | | |
| Physical Address of Business (include ZIP code, no P.O. box):code, no P.O. box): | | Standard Industry Code (SIC, 4 digit): | | | | | | |
| Rate Proposal – Our rate proposal will include health plans, dental plans, vision plans (for groups with 10+ enrolling employees), and life/disability coverage. | 2 Eligible, 1 Enrolling Employee (resulting in 1 contract) – Each employee must complete a Small Business Enrollment Application/Change Form which includes a statement of health. | 2-50 Enrolling Employees (resulting in 2+ contracts) – A company representative must complete a Group Employer Medical Questionnaire. A complete census is also required. | | | | | | |
| Name of Current Health Care Carrier: | | | | | | | | |
| Employee Count ____ Total employees on payroll + ____ New hires not yet on payroll - ____ Part-time employees working fewer than 24 hours per week or other part-time staff to whom the employer is not offering coverage - ____ Seasonal and temporary employees - ____ Terminated employees = ____ Total employee count NOTE: If the result is between two and 50, the employer is a candidate for small group coverage. | | Life, AD&D: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 (default) <input type="checkbox"/> Other amount, please specify: _____ Life, AD&D: <input type="checkbox"/> Percentage of Salary: _____% (Please include salary for each employee provided on the census) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Voluntary Life | | | | | | |
| Important Information for groups with 2-9 enrolling employees Monthly premium amounts can be provided for each eligible employee listed on the census. You may request specific benefit plans to include this level of detail. Specify up to 5 plan name(s) below. Examples: RYB409 or RW485. _____, _____, _____, _____, _____ | | Disability: <input type="checkbox"/> STD (default \$200 weekly) <input type="checkbox"/> LTD <input type="checkbox"/> Voluntary STD <input type="checkbox"/> Voluntary LTD | Dental: <input type="checkbox"/> Voluntary Dental (Group Size: 2+) | | | | | |
| Census Information* – can be filled out below or attached | | | | | | | | |
| Last Name | First Initial | DOB (mm/dd/yyyy) preferred OR Age (in years) | Gender (M or F) | Coverage Type EO - Emp. EC - Emp.+Ch ES - Emp.+Sp EF - Emp. +Fam | No. of Children | Home ZIP (5 digits only) | Employment Status (FT, PT, Seasonal, Temp, Terminated) | Salary Life Only |
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| *For 2-9 enrolling employees, DOB preferred for all dependents applying for coverage. Spouse and children birthdates allow us to provide more accurate rates. | | | | | | | | |