

REQUEST FOR PROPOSAL

PLEASE COMPLETE THE INFORMATION and CHECK THE APPROPRIATE BOX(S) IN ORDER TO HAVE YOUR QUOTE PROCESSED

Prospect Name: _____

Location: City _____ State _____ Zip _____

Other Locations: _____

Requested Eff. Date: _____ Current Carrier _____ Current RAF: _____

Please provide a copy of the current and/or renewal billing statement and a copy of the group plan design.

Industry: _____ Employer Contribution: _____ Dep: _____

Years in Business: _____ Owners Enrolling: Yes No # of EE's: Full-time: _____ # of COBRA's: _____

Legal Structure of Business: Corporation Partnership Sole Proprietor Current Group Coverage Yes No Carrier: _____

REQUESTED BENEFITS	<input type="checkbox"/> HMO	<input type="checkbox"/> EPO	<input type="checkbox"/> PPO	<input type="checkbox"/> POS	<input type="checkbox"/> HSA	<input type="checkbox"/> HRA	<input type="checkbox"/> Dental
	<input type="checkbox"/> LTD	<input type="checkbox"/> STD	<input type="checkbox"/> Vision	<input type="checkbox"/> Life/AD&D	<input type="checkbox"/> Supp Life	<input type="checkbox"/> Dependent Life	

CHOOSE HEALTH CARRIER	<input type="checkbox"/> Aetna	<input type="checkbox"/> Anthem Blue Cross	<input type="checkbox"/> Cal Choice	<input type="checkbox"/> KP Choice	<input type="checkbox"/> Cigna	<input type="checkbox"/> Health Net	<input type="checkbox"/> PacifiCare	<input type="checkbox"/> United HealthCare	<input type="checkbox"/> Sharp
	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Kaiser							

HMO Dr. Office Copay: \$10 \$15 \$20 \$25 \$30 \$35 \$40 \$45
 Hospital Coverage: 100% 80% Other: _____

PPO Dr. Office Copay: \$10 \$15 \$20 \$25 \$30 \$40
 POS Deductible: \$200 \$250 \$300 \$500 \$1,000 \$1,500 \$2,000 +
 Other: _____

CHOOSE DENTAL	<input type="checkbox"/> Aetna	<input type="checkbox"/> AIG	<input type="checkbox"/> Ameritas	<input type="checkbox"/> Anthem Blue Cross	<input type="checkbox"/> BEST	<input type="checkbox"/> Cigna	<input type="checkbox"/> Delta Dental	<input type="checkbox"/> Golden West
	<input type="checkbox"/> Health Net Dental	<input type="checkbox"/> Humana	<input type="checkbox"/> Met Life	<input type="checkbox"/> PC/UHC	<input type="checkbox"/> Safeguard			

Dental: DMO Indemnity/PPO Dual Option Voluntary
 Preventive: _____ Basic: _____ Major: _____
 Deductible: _____ Ortho: _____ Maximum: _____

CHOOSE VISION	<input type="checkbox"/> AIG	<input type="checkbox"/> Ameritas	<input type="checkbox"/> Avesis	<input type="checkbox"/> Anthem Blue Cross	<input type="checkbox"/> BEST	<input type="checkbox"/> Delta Dental/EyeMed	<input type="checkbox"/> Golden West
	<input type="checkbox"/> Health Net Vision	<input type="checkbox"/> Humana	<input type="checkbox"/> PacifiCare/UHC	<input type="checkbox"/> Safeguard	<input type="checkbox"/> USA Vision - VSP		

CHOOSE LIFE/AD&D	<input type="checkbox"/> Aetna	<input type="checkbox"/> AIG	<input type="checkbox"/> BEST	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Hartford	<input type="checkbox"/> Health Net	<input type="checkbox"/> Humana
	<input type="checkbox"/> MetLife	<input type="checkbox"/> United HealthCare					

Life & AD&D: Amount Requested: Minimum \$15,000 \$25,000 \$50,000 Other: _____

CHOOSE LTD/STD	<input type="checkbox"/> AIG	<input type="checkbox"/> MetLife	<input type="checkbox"/> Hartford
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LTD: Elimination Period: 30 Days 60 Days 90 Days 180 Days
 Benefit Percentage: 60% 66-2/3%
 Maximum Monthly Benefit: Benefit Amount \$ _____ Own Occupation: _____

COMMENTS: _____

BROKER NAME Bryan McDonald **AGENCY** Beach Cities
 Address P.O. Box 185 City Corona Del Mar, CA Zip 92625
 Phone (949) 720-1401 Fax (949) 720-1489 E-Mail bryan@beachins.com

Proposal Delivery Options: E-Mail Bind & Mail Pick Up

EMPLOYEE CENSUS

Prospect Name:

	Last	First	M/F	DOB/Age	EE	EE + SP	EE + CH	EE + FM	Home Zip	Job Title *	Annual Salary *
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* Required for LTD/STD

BROKER NAME _____

AGENCY _____

DATE COMPLETED _____