

Employer Group Proposal Request



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Date:	Contact:
Group Name:	
Group Address:	Phone:
Fax:	
Zip Code:	Industry:
Mailing Address:	

Please provide information on your current plan:

Carrier:_____ Plan Type:_____

PPO:_____Deductible/Co-pay

HMO:_____Out of Pocket Max.

Current Rates: Empl:_____ Empl & Spouse:_____

Empl & Children:_____ Family:_____

Renewal Rates: Empl:_____ Empl & Spouse:_____

Empl & Children:_____ Family:_____

Dental:_____ Vision:_____ STM Disability:_____

LTM Disability:_____ Life:_____

Employee Census: (Please refer to tables 1&2 to complete census form)

Table 1: Enrollment Status

- 1 = Employee Only
- 2 = Employee + Spouse
- 3 = Employee + Child(ren)
- 4 = Family
- 5 = NOT Enrolling

Table 2: Reason NOT Enrolling

- 1 = Other Coverage
- 2 = Probationary Period
- 3 = Not Eligible
- 4 = Other

	Employee Name	Date of Birth	Gender M/F	Over 17.5 Hrs/Wk Y/N	Enrollment Status (see table 1 above)	Reason if NOT Enrolling (see table 2 above)
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