

# REQUEST FOR A PROPOSAL



Date:

Need Proposal by:

Effective Date Requested:

Prospect's Name & Address

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Other Locations

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Nature of Business:

Description of Present Coverage

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Present Fully Insured or Stop-Loss Rates

EE	EE +1	EE +2 or more
<b>Specific Retention:</b>		
<u>Aggregate Factors</u>		
EE	EE +1	EE +2 or more

## COVERAGES REQUESTED

	Option I	Option II	Option III
<b>Specific Retention:</b>			
<b>Terms:</b>			
<b>Aggregate Coverage:</b>			
<b>Terms:</b>			
<b>Include in Aggregate:</b>			
<b>Basic Life/AD&amp;D:</b>			
<b>Present Basic Life Rates:</b>			
<b>Present AD&amp;D Rates:</b>			
<b>Voluntary Life:</b> (describe)			
<b>Long Term Disability:</b> (describe)			
<b>Cafeteria</b> Child Care FSA			

## EMPLOYER CONTRIBUTIONS

<u>Medical Plan(s)</u>				<u>Other Coverages</u>		
	Self-Funded	HMO	PPO			
Single:				Basic Life:		
Dependents:				LTD:		

CENSUS (attach disc)

Commission Requested

Single:				Stop-Loss	Basic Life	Admin
Family:						

**SELF-FUNDED BENEFITS / NOTES**

**MEDICAL CONDITIONS**    please attach a separate disclosure sheet

Select office to send form to:    CA                      CO