

## REQUEST FOR GROUP PROPOSAL

## **INSTRUCTIONS:**

- 1. Complete all sections and submit along with Census Information.
- 2. Attach Claims Experience for last 3 years
- 3. Attach Current Schedule of Benefits and Current Billing (if applicable)

N.B. Compliance documents (Customer Identity Form - Corporate, copies of Corporate Documents, ID's and other relevant documents) are mandatory upon acceptance of a proposal and with all applications for CaricareAdvantage and Elite Plans. No new group health or life business will be effected if these documents are not submitted.

## **CLIENT INFORMATION**

PROSPECTIVE CLIENT:				NATURE OF BUSINESS:				
ADDRESS:				CONTACT PERSON:				
				TITLE:				
BRANCHES / SUBSIDIARIES:				TELEPHONE #:				
				FAX #:				
			EMAIL:					
Does firm have Existin	g or Past cov	erage? Y	ES [	□ NO □				
If YES, name Carrier		_						
Effective Date of Exist	ing Plan	mm	ı/dd/y	ууу				
Why is a change in Car	rrier being co	nsidered? _						
When does present pla	n renew?	m	n/dd/y					
How much does <b>Emplo</b> the cost of the Plan?	<u>oyer</u> contribu		, aa, y	<u>%</u>				
Does client require a F	Retiree Divisio	on? YES	ľ	NO 🗌				
Please list client's current rates "a."								
Is there a rate increase pending?			YES NO If yes, please complete "b"					
BENEFITS	a. CURRENT RAT			ES	b. PENDING RATE CHANGE			
	Single	Emp + 1		Family	Single	Emp + 1	Family	
Medical								
Dental								
Vision								
TOTAL								
Life								
AD&D								
Critical Illness								

COVERAGE REQUIRED	
Total Number of Employees:	
Number of Eligible Employees:	
Number of Ineligible Employees:	
If Ineligible Employees exist, please elaborate:	
SMALL GROUP Major Medical Maximum	<u>LARGE GROUP</u> <u>Proposed Maximums</u>
CariCAREAdvantage \$400,000	Comprehensive Major Medical
CariCARE Elite \$500,000	Dental
*Include Dental & Vision	V ISIOII
	Recommendations:
*N.B. Dental and Vision coverage is OPTIONAL for	
CariCARE Advantage and Elite.	
ALL SMALL GROUP OPTIONS INCLUDE DALIAN	
Life and Accidental Death and Dismemberment coverage	
at a minimum of \$50,000 is <u>mandatory</u> for small groups.	Include DALIAN?: YES NO
	Hende DALLER.
GROUP LIFE &AD&D: YES ☐ NO ☐	CRITICAL ILLNESS: YES NO
BENEFIT FORMULA: 200% Annual Salary	BENEFIT FORMULA: 100% Annual Salary
300% Annual Salary 400% Annual Salary	200% Annual Salary
500% Annual Salary	FLAT BENEFIT: e.g. \$50,000, \$75,000up to \$250,000:
FLAT BENEFIT: e.g. \$50,000, \$75,000up to \$250,000:	
AGENT/ BROKER	
Name: Telephone	No.: Fax:
(IN BLOCK LETTERS)	
Email:	a veg $\square$ no $\square$
Are you the Agent/Broker on record for this client's existing plan	
Has this client appointed you the Agent/Broker?	YES NO
••	llow within 5 working days
I have read and completed the above information. I certify that a	Il information is accurate to the best of my knowledge. YES
Agent/Broker Signature:	AGENT#: DATE:mm/dd/yyyy
BRANCH MANAGER:	DATE:
	mm/dd/yyyy