PROPOSAL REQUEST

BROKER INFORMATION

Broker Name: ____________________

Agency: ____________________

Address: ____________________

City: ____________________, State: __________ ZIP: __________

Phone: ____________________ Fax: ____________________

Email Address: ____________________

BUSINESS/GROUP INFORMATION

Company Name: ____________________

Company Zip: __________ Company County: ____________________

Nature of Business: ____________________ SIC Code: __________

Number of full-time employees: __________
(30+ hours/week)

Number of part-time employees __________
(20-29 hours/week)

Percent of cost to be paid by Employer

______ % of Employee Cost ______ % of Dependent Costs Desired Effective Date: __________

Current Health Plan: ____________________ Current Premium: ____________________

Current Plan Type: ☐ HMO ☐ PPO ☐ EPO ☐ HSA ☐ POS

Are you with a PEO? ☐ Yes ☐ No

Does your group have Dental coverage? ☐ Yes ☐ No If yes, number of years: ______
Contribution: ____________________ % participation ____________________

Does your group have Vision coverage? ☐ Yes ☐ No If yes, number of years: ______
Contribution: ____________________ % participation ____________________

Does your group have LTD coverage? ☐ Yes ☐ No If yes, number of years: ______
Contribution: ____________________ % participation ____________________

Does your group have Life coverage? __________ ☐ Yes ☐ No
If yes, what is the Life amount for each employee? ____________________

CENSUS

Company Name: ________________________ **Broker Name:** ________________________

Fill in the columns below. Fields marked with an asterisk (*) are mandatory.

1. Enter the Employee first, then every other family member (spouse and children) to be covered on subsequent lines. The Employee ID should be entered sequentially and the same number should be used for each family member. Each person's Date of Birth is mandatory for quoting.
2. After the full family is entered, the next Employee should be started on the following lines. Do not skip a line between employees.

COVERED MEMBER KEY		
E or 1 = Employee	**S or 2** = Spouse/Domestic Partner	**D or 3** = Other Dependents

SAMPLE

EMPLOYEE ID	COVERED MEMBER CODE*	LAST NAME	FIRST NAME	GENDER (M/F)	DATE OF BIRTH (MM/DD/YYYY)	ZIP CODE EMPLOYEE ONLY	EE ON COBRA? (Y/N)
1	E	Doe	John	M	09/19/1968	90000	N
1	S	Smith	Jane	F	10/07/1969	90000	N
1	D	Doe	Tom	M	12/15/2000	90000	N

* Every person to be covered is rated individually. Rates vary by age and any change in the date of birth of an employee, spouse, or dependent will cause the quoted rates to be different. Any change to the ZIP code and/or number of dependents can also cause the rates to be different.

Fax completed census to the office nearest you:

Orange
701 South Parker, Ste. 8000
Orange, CA 92868
Fax: 714.953.9404

Inland Empire
3633 Inland Empire Blvd., Ste. 525
Ontario, CA 91764
Fax: 714.908.3590

Los Angeles
801 N. Brand Blvd., Ste. 900
Glendale, CA 91203
Fax: 800.355.9711

Northern California
1737 N. First Street, Ste. 680
San Jose, CA 95112
Fax: 800.719.7223

San Diego
3131 Camino Del Rio North, Ste. 820
San Diego, CA 92108
Fax: 619.299.2070

Nevada
7201 West Lake Mead Blvd., Ste. 220
Las Vegas, NV 89128
Fax: 800.700.6744

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