

GROUP HEALTH INSURANCE - Request for Proposal

Company Information:

Company Name:

Owner:

Address 1:

Address 2:

City: State: Zip:

Phone: FAX Number:

Email Address:

Current Coverage:

Carrier: Premium:

Type of Business:

Please Provide a Proposal for the following Benefits:

Medical Dental Vision Life

Company Census:

| Employee Name | Gender (M/F) | DOB (MM/DD/YYYY) | Dependant Status | Employee Zip Code |
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Desired Effective Date:

Optional coverage's:

Maternity Prescription Card Dental Vision Life / AD&D