

# PROPOSAL REQUEST FORM

PROPOSED EFFECTIVE DATE: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

CONTACT: \_\_\_\_\_ PHONE#: (\_\_\_\_) \_\_\_\_\_

TITLE: \_\_\_\_\_ FAX#: (\_\_\_\_) \_\_\_\_\_

TYPE OF BUSINESS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

REASON FOR QUOTE: \_\_\_\_\_

ELIGIBILITY WAITING PERIOD:  30 days  60 days  90 days  Other \_\_\_\_\_

	MEDICAL	DENTAL
EMPLOYER CONTRIBUTION TOWARD <u>EMPLOYEE</u> PREMIUMS (% OR \$ AMOUNT):	_____	_____
EMPLOYER CONTRIBUTION TOWARD <u>DEPENDENT</u> PREMIUMS (% OR \$ AMOUNT):	_____	_____
CURRENT INSURANCE CARRIER: MEDICAL: _____ DENTAL: _____		

Are there any employees residing outside of the state of Oregon?  Y  N

If yes, list: City/State Zip Code # of Emp

\_\_\_\_\_

\_\_\_\_\_

Are there any employees residing outside of the county for which the group is located?  Y  N

If yes, list: City/State Zip Code # of Emp

\_\_\_\_\_

\_\_\_\_\_

## PLAN TYPE

CURRENT TYPE OF PLAN:  Managed Care Look-a-Like  POS  PPO  Indemnity

REQUESTED TYPE OF PLAN:  Managed Care Look-a-Like  POS  PPO  Indemnity

## BENEFITS

MEDICAL	CURRENT	REQUESTED	DENTAL	CURRENT	REQUESTED
Deductible	_____	_____	Deductible	_____	_____
Office Visit	_____	_____	Preventive Services	_____	_____
Coinsurance	_____	_____	Basic Services	_____	_____
Out of Pocket	_____	_____	Major Services	_____	_____
Plan # (if known)	_____	_____	Maximum	_____	_____
PRESCRIPTION DRUGS	_____	_____	Plan # (if known)	_____	_____
CHIROPRACTIC	_____	_____	ORTHODONTIA	_____	_____
VISION	_____	_____	OTHER	_____	_____

## RATES

	CURRENT				RENEWAL*			
	EE	EE/SP	FAM	EE/CH	EE	EE/SP	FAM	EE/CH
MEDICAL	_____	_____	_____	_____	_____	_____	_____	_____
RX	_____	_____	_____	_____	_____	_____	_____	_____
VISION	_____	_____	_____	_____	_____	_____	_____	_____
DENTAL	_____	_____	_____	_____	_____	_____	_____	_____

\*Note: For groups of 51-99, renewal rates or 12 months of experience is required. For groups of 100+ ees, 12 months of experience is required.

## AGENT

(IF YOU HAVE AN INSURANCE AGENT REPRESENTING YOU, PLEASE COMPLETE BELOW:)

INSURANCE AGENT: \_\_\_\_\_

INSURANCE AGENCY: \_\_\_\_\_ PHONE#: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX#: (\_\_\_\_) \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ E-MAIL: \_\_\_\_\_