Large Group Proposal Request

Marketing In Date:

Client Name:	Client Street Address/City/State/Zip	County:
Agent Name:	Agent E-mail Address:	Sales Representative:
Agent Phone:	Agent Fax:	Deadline for Quote:

Coverages Requested: ☐ **Medical** ☐ **Dental**

Special Funding Requests: ☐ **Retrospective Arrangement** ☐ **Self-funding** ☐ **PSA (FSA, HRA)**

Effective Date of Quote:

"Small employer" means (in connection with a group health plan with respect to a calendar year and a plan year) an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Full-Time Equivalent Definition: The average number of employees in the preceding calendar year, including full-time and part-time, working an average of 30 hours or more a week. *Excludes: seasonal, temporary, leased, contracted, retired or former employees on continuation of coverage, sole proprietor and their spouse, partner in a partnership and their spouse, 2% S corporation shareholder and their spouse, or real estate agent or direct seller (as described in 26 U.S.C. Section 2508).*

Is this group a Large Employer? ☐ **Yes** ☐ **No**

Total # of Full-Time Equivalent employees on average during the preceding *CALENDAR* year:		
Total # of employees as of the effective date of coverage:		
Total # of employees eligible for coverage:		
Total Number Waiving: WITH Other GROUP Coverage: _____ WITHOUT Other GROUP Coverage: _____	Med	Dent
Subtotal:		
Probationary Employees:	+	
COBRA:	+	
Retirees:	+	
Total Enrolling:	=	

Notes:

☐ **Employer Contribution**: Medical: _____/_____ Dental: _____/_____

☐ **Industry/SIC Code**: _____

☐ **Medical Carrier:** _____ ☐ **Medical Renewal Date**: _____

☐ **Medical/Rx Plan Design**: _____

☐ **Other Optional Riders:** _____

☐ **Current Medical/Rx Rates: EE:** _____ **ES:** _____ **EF:** _____ **EC:** _____

☐ **Renewal Medical/Rx Rates: EE:** _____ **ES:** _____ **EF:** _____ **EC:** _____

☐ If off-renewal, reason: _____

☐ **Dental Carrier:** _____ ☐ **Dental Renewal Date:** _____

☐ **Dental/Ortho Plan Design:** _____

☐ **Current Dental Rates: EE:** _____ **ES:** _____ **EF:** _____ **EC:** _____

☐ **Renewal Dental Rates: EE:** _____ **ES:** _____ **EF:** _____ **EC**: _____

☐ If off-renewal, reason: _____

☐ **Number of insurance companies in the last five years?** _____ **List companies/effective dates:**

_____ _____

_____ _____

☐ **Claims Experience & Large Claims Report** ☐ **MEDICAL** ☐ **DENTAL**
(REQUIRED FOR ALL 100+ GROUPS AND ALL LARGE SELF-FUNDED GROUPS)

Enrolling Out-Of-State Employees—Total:

#Emps	City, State or Zip

AU In Date:	Client #:	Proposal #	Processed by:	Date Out: