



PROPOSAL REQUEST

Date of Request: _____ Proposal needed by: _____

1. EMPLOYER DATA				
Employer Name _____			Requested Plan Effective Date _____	
City _____	State _____	County _____	Zip _____	
SIC Code or Nature of Business _____			Divisions included: <input type="checkbox"/> Yes <input type="checkbox"/> No	
2) AGENT DATA (AGENT MUST BE LICENSED WITH CARRIER)				
Agent Name _____			Phone Number _____	
Agency Name _____			Fax Number _____	
E-mail _____				
3. PLAN CHOICES		Provided on a group basis - must be for all eligibles in Plan.		
A) MEDICAL (All plans use the Cofinity PPO network with MultiPlan used for out of state claims.)				
<input type="checkbox"/> 100/70 - Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> 90/70 - Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> 90/60 - Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> 80/50 - Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> 70/50 - Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000
CoPay: <input type="checkbox"/> \$20.00 <input type="checkbox"/> \$30.00 <input type="checkbox"/> \$40.00		Coinsurance: <input type="checkbox"/> % of \$12,500 - (Not available with 100/70 plans.) <input type="checkbox"/> % of \$15,000 <input type="checkbox"/> % of \$20,000		
<input type="checkbox"/> Deductibles and Coinsurance COMBINED in and out of Network			<input type="checkbox"/> Deductibles and Coinsurance SEPARATE in and out of Network	
B) HSA Plan Options:				
Deductibles and Coinsurance COMBINED in and out of Network: Coinsurance: <input type="checkbox"/> 100/70 <input type="checkbox"/> 80/60 Deductible: <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000			Deductibles and Coinsurance SEPARATE in and out of Network: Coinsurance: <input type="checkbox"/> 100/70 <input type="checkbox"/> 80/60 Deductible: <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000	
C) Is there a current HRA plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the deductible? _____				
D) PRESCRIPTION DRUG (Does not apply to HSA plans)				
<input type="checkbox"/> \$10 Generic/\$40 Brand <input type="checkbox"/> \$10 Generic/\$50 Brand <input type="checkbox"/> \$5 Generic/\$25 Preferred Brand/\$50 Non-Preferred Brand <input type="checkbox"/> \$15 Generic/\$40 Preferred Brand/\$80 Non-Preferred Brand <input type="checkbox"/> \$20 Generic/\$50 Preferred Brand/\$100 Non-Preferred Brand All plans include a 25% coinsurance for Level IV drugs, limited to \$3,500 per member co-pay per calendar year.				
E) LIFE/AD&D COVERAGE			EMERGENCY ROOM CO-PAY	
<input type="checkbox"/> Flat \$15,000 (Mandatory Minimum) <input type="checkbox"/> Occupational Class (include job) <input type="checkbox"/> Flat Amount - Other \$ _____ <input type="checkbox"/> X Salary (include salary data)			<input type="checkbox"/> \$150 <input type="checkbox"/> \$250	
4. INFORMATION REQUIRED FOR QUOTATION:				
- Employee Name, DOB, Sex, Dep. Status, County (If Employer has multiple locations, provide zip and county information.) - Total Number of Full-Time Employees _____ (Participation must be a minimum of 75% of eligible.) - Total Number of COBRA Lives _____ - Current Carrier _____ Fully Insured ___ Self Insured ___ w/ Stop Loss Protection - Copy of Current Schedule of Benefits/Current Rates/Renewal Rates				
Email requests to: gorskoh@secureoneinc.com Fax requests to: (616) 454-4338 Instructions: Complete all sections to guarantee a rapid quote. Missing information will delay our ability to process your proposal request.				

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 Administered by SecureOne Benefit Administrators, Inc.
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