



**Proposal Request Form**

Employers 2EE to 99 EE

Date of Request: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**EMPLOYER DATA**

Employer Name: \_\_\_\_\_ SIC Code: \_\_\_\_\_

Address: \_\_\_\_\_ Total Full-Time Employees: \_\_\_\_\_

City: \_\_\_\_\_ State: OH Zip Code: \_\_\_\_\_

**AGENT DATE (must be licensed with carrier if group sells)**

Agent Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Email quote to: \_\_\_\_\_

**Agent Compensation**

- \$15    \$20    \$25  
 \$30    \$\_\_\_\_\_

**MEDICAL PLAN CHOICES (maximum 3 between PPO & HSA)**

\*All deductibles and co-insurance are SEPARATE in- and out-of-network.

**PPO PLANS**

\*All have \$30 Office Visit Co-pay and "ACA" Max OOP is \$7,900 Single/\$15,800 Family for In-Network.

100/70		90/60		80/50		70/50	
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000
<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,000
<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000
<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000
		<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,000

**Rx Options:**    \$5/\$25/\$50/25%    \$15/\$40/80/25%    \$20/\$60/\$100/25%

**ER Co-Pay:**    \$150    \$250

**Co-Insurance:**    \$15,000    \$20,000

\*\*Should Deductible and Co-Insurance fall below the maximum "ACA" out-of-pocket limit chosen by the employer, co-pays will apply up to the maximum "ACA" Allowable amount.

**HSA PLANS**

"ACA" Max OOP is \$6,750 Single/\$13,500 Family

100/70				80/60			
<input type="checkbox"/> \$1,350	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,350	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000
<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$6,000				<input type="checkbox"/> \$6,000			

**LIFE INSURANCE**

\$15,000 flat mandatory minimum    \$\_\_\_\_\_ Flat Amount (up to \$50,000)

**All Employees and covered dependents must complete an Employee Health Risk Assessment Applications!**

Please send this completed form and the following information to [gorskoh@secureoneinc.com](mailto:gorskoh@secureoneinc.com) or fax 616-454-4338.

- Census (name, dob, sex, Dep status, zip code if not in MI)
- Current Schedule of Benefits
- Current Carrier \_\_\_\_\_

