



Preferred United Plans[®]
"Alternative Funding"
Employers 2 EE to 125 EE



Date of Request: _____

Effective Date: _____

1. EMPLOYER DATA

Employer Name _____ City _____ State _____ Zip Code _____

SIC Code or Nature of Business _____ Number of Employees _____

2. AGENT DATA (AGENT MUST BE LICENSED WITH CARRIER)

Agent Name _____ Agency _____

E-Mail Address _____ Phone Number _____ Fax Number _____

Agent Compensation: _____ \$15 PEPM _____ \$20 PEPM _____ \$25 PEPM _____ OTHER \$ _____

3. PLAN CHOICES:

MEDICAL— NO MORE THAN THREE (3) SELECTIONS (BETWEEN PPO AND HSA)

Plans	_____ 100/70	_____ 90/60	_____ 80/50	_____ 70/50
Deductibles	_____ \$1,000 _____ \$2,000 _____ \$2,500 _____ \$3,000 _____ \$4,000 _____ \$5,000	_____ \$500 _____ \$1,000 _____ \$2,000 _____ \$2,500 _____ \$3,000 _____ \$4,000 _____ \$5,000	_____ \$500 _____ \$1,000 _____ \$2,000 _____ \$2,500 _____ \$3,000 _____ \$4,000 _____ \$5,000	_____ \$500 _____ \$1,000 _____ \$2,000 _____ \$2,500 _____ \$3,000 _____ \$4,000 _____ \$5,000

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

*Maximum out-of-pocket allowed based upon 2014 "ACA" Requirements is \$6,600 Single/\$13,200 Family for In-Network.
 **Should Deductible and Co-Insurance fall below the "ACA" allowance chosen by the employer, co-pays will be applied up to the "ACA" allowable maximums.

Rx Options: _____ \$5/\$25/\$50/25% _____ \$15/\$40/\$80/25%

ALL PLANS HAVE A \$30 OFFICE VISIT CO-PAY AND A \$150 ER CO-PAY
All plan options: All Deductibles and Co-insurance are SEPARATE in and out of Network

HSA—Max OOP for HSAs is \$6,450 Single/\$12,900 Family

Plans	_____ 100/70	_____ 80/60
Deductibles	_____ \$1,300 _____ \$1,500 _____ \$2,000 _____ \$3,000 _____ \$4,000	_____ \$1,300 _____ \$1,500 _____ \$2,000 _____ \$3,000 _____ \$4,000

Life Insurance: _____ Flat \$15,000 (Mandatory Minimum) _____ Flat Amount \$ _____

All Employees and Covered Dependents Must Complete an Employee Health Risk Assessment Application!

- INFORMATION REQUIRED:**
- ❖ Census: Name, DOB, Sex, Dep Status
 - ❖ Total Number of Full Time Employees _____
 - ❖ Total Number of COBRA lives (If COBRA eligible) _____
 - ❖ Current Carrier _____
 - ❖ Current Schedule of Benefits _____
- * All Information Must be Present To Receive Proposals!!**



E-Mail requests to : goskoh@secureoneinc.com
 Fax requests to 616-454-4338