Information For Limited Benefit Medical Proposal

AGENT/BROKER INFORMATION:

Name: ______________________ Email: ______________________

Phone #: ______________________ Fax #: ______________________

Are you affiliated with an agency? ☐ Yes ☐ No Agency Name: ______________ license #: ______________

Street: ______________ City: ______________ State: __________ ZIP: __________

GENERAL INFORMATION:

Employer Name: ______________________ Industry: ______________

Address: ______________________ SIC Code: ______________

City: ______________________ State: ________ Zip: ________

Contact Name: ______________________ Title/Dept: ______________

Address (if different): ______________________

City: ______________________ State: ________ Zip: ________

Phone #: ______________________ Fax #: ______________

Email: ______________________

Will eligibility extend to employees of Subsidiaries or Affiliates? ☐ Yes ☐ No

If Yes, please list the Subsidiaries or Affiliates: ______________________

Does the Employer have a DBA? ☐ Yes ☐ No

If Yes, provide name(s): ______________________

Is this Policy replacing existing coverage? ☐ Yes ☐ No

If Yes, please describe: ______________________

Payroll Cycle: ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly

*ELIGIBILITY:

Total Number of Employees: ______________________

Number of Eligible Employees **(this Plan)**: ______________________ Eligibility Waiting Period (if any): ______________

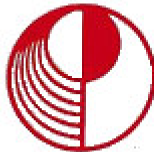
Average Eligible Employee Age: ______________________

Definition of Eligible Employee: ______________________

Requested Policy Effective Date: ______________________ (Minimum 90-day notice required)

***Include the total number of all employees in the group, as well as, the number of employees that are eligible for this plan. For average age, add up the actual ages of the employees eligible for this plan and devide the the number of employees eligible for this plan.**

Email or Fax this Form to:



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