

PROFESSIONAL BENEFITS SERVICES

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REQUEST FOR SELF-FUNDED GROUP HEALTH PROPOSAL

Name:	Date:
Address/Main Location:	SIC Code/Industry:
Address/Other Locations:	Phone
Current # Participants: Sgl. 2prsn. Fam.	Effective Date:
<input type="checkbox"/> Self Funded <input type="checkbox"/> Fully Insured	

SELF FUNDED

Carrier:	Network:	TPA:
Specific Deductible: \$	Current Contract Basis:	
Specific Rates:	Single: \$	Family: \$
Aggregate Premium:	Monthly: \$	Annual: \$
Commission:	<input type="checkbox"/> Included in Rates	<input type="checkbox"/> Not Included in Rates
Aggregate Factors:	Single	Family
Covered Under the Aggregate:	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Short Term Disability	

FULLY INSURED

Current Carrier:			
Current Rates:	Single \$	Double \$	Family \$

Current Plan of Benefits: See Attached Benefits are as follows

The following information has been enclosed:

- | | |
|--|---|
| <input type="checkbox"/> Census * | <input type="checkbox"/> Shock Loss Information (over 50 %) |
| <input type="checkbox"/> Claims Experience * * | <input type="checkbox"/> Schedule of Benefits |

* Incl. Gender, date of birth, coverage level (Single., Double, Family)

** **Self-Funded** – any size; **Fully Inured** over 100 lives. At least 2-3 yrs. claims experience.

Include enrollment by month.

Please issue quote as follows:

Commission Level:

Specific Deductible(s): \$10,000 \$12,500 \$15,000 \$20,000 \$25,000 \$30,000 \$35,000
\$40,000 \$45,000 \$50,000 \$60,000 \$75,000 \$100,000
Other:

Contract Type(s): 12/12 12/15 15/12 18/12 24/12 Other:

Specific Coverage: Medical Rx Dental Vision Short Term Disability

Aggregate Coverage: Medical Rx Dental Vision Short Term Disability

PPO Network(s): PPOM Real Health NPPN CHA/EMO Beech Street CCN
Preferred Choices Medical Resource Other:

Plan of Benefits: Duplicate current plan Assume plan of benefits is as follows:

DATE QUOTE NEEDED:

Please do one of the following to return this form:

By Fax or Mail:

- Print and fill out the form.
OR
- You may fill in this form by typing your options directly into it and then print it.
AND
- Fax or mail it to number or address at the top of this form.

By E-mail:

- You may fill in this form by typing your options directly into it.
- Save it to your hard drive, then e-mail it to tlaplant@professionalbenefits.net.

**If you have any questions,
Please Contact TRACEY LA PLANT at 1-800-732-3412.
Thank you.**