ERIC WALTERS
PEO Consultant-Payroll, WC insurance & Employee Benefits
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REQUEST FOR GROUP HEALTH PROPOSAL

Date:

Employer: **SIC CODE**…….……

Address:

Email: **Phone:** **Fax:**

Contact Person: **Other Locations:**

Type of Industry: **Years in Businesss:…..…**

Total EE: FT: **PT:** **Eligible:…….** **To be Insured:..……..….**

Current Carrier/Plan Terms: .

PPO: Ded: **POS: Ded** **HMO:Inpatient Fee:**

Max OOP- Indiv-InNetwork: PPO: **POS:** **HMO:**

Physician/specialist: **PPO:** **POS:** **HMO:**

Drug Copays: **PPO:** **POS:** **HMO**
Drug deductible: **PPO:** **POS:** **HMO**

Plan 1.
Current premiums- EE:…….ES…….EC……..Family…….
Plan 2
Current premiums- EE:…….ES…….EC……..Family…….
Plan 1.
Renewal Premiums- EE……..…ES…….EC…….Family……..
Plan 2.
Renewal Premiums- EE……..…ES…….EC…….Family……..

Renewal Date:

BENEFITS REQUESTED

Health: -

PPO/POS: Deductible: $500, $1,000, $1,500, $2,000, $2,500, $3,000, $5,000, $10,000 (Other?)

CoInsurance: 100%, 90%, 80%, 70%, 60%, 50%

HMO

We provide quotes for plans with varying deductibles and co-insurance from a variety of insurers!

Short Term Medical:

Limited Benefit Plans:

Life: Employee:$…… Dependents:$…..……..
Employer Cost: Yes/No

Dental: Vision:
Employer Cost: Yes/No

Disability Income (S/LT) % of monthly income:……Waiting Period:…….
Employer Cost: Yes/No

Employer Contribution: Health:

EE:$.....%.....ES$.....%.....EC$.....%.....Family$.....%.....

Vision: EE$.....%.....DEP$.....%..... Dental: EE$.....%.....DEP$.....%.....

401K:

Sec 125/Flexible Spending Account:

Effective Date:

Other Requests:

Please include a copy of current premium bill and schedule of benefits if applicable

Fax or Email

ewinsurance@gmail.com/-FAX- 480-657-8591

Eric Walters

PEO/Insurance services- Health, Life & Annuity

14482 N 100th Place, Scottsdale AZ 85260

Tel:- 480-657-8595/Fax:- 480-657-8591

Cell: 602-616-1660/Email:EWinsurance@gmail.com

UNDERWRITING QUESTIONNAIRE

Company Name: _____

1. Number of Full-Time EE's: _____ Number Eligible for Health Coverage: _____ Number of Participants: _____
2. Current Insurance Carrier or PEO: _____ Eff. Date: _____ Renewal Date:_____
3. Type of Coverage (please circle): HMO POS PPO Catastrophic/Other
4. Please indicate your current and renewal rates below (*if this is not your renewal period, include last year's rates instead*):

   Current Rates: Employee $_____ EE+SP $_____ EE+CH $_____ Family $_____

   Renewal Rates: Employee $_____ EE+SP $_____ EE+CH $_____ Family $_____

5. Please answer the following questions to the best of your knowledge. *Please do not disclose the name of any employee or dependent*. Give details to "yes" answers below. Use additional sheets if necessary.

		YES	NO
a)	Are any employees or dependents currently pregnant? If yes, what trimester? _____	❒	❒
b)	Are any of the employees currently disabled, hospitalized or not actively at work?	❒	❒
c)	Did any employee, dependent or COBRA participants incur over $5,000 in claims in the last 24 months?	❒	❒
d)	Do any employees or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary?	❒	❒
e)	Have any employees, dependents or COBRA participants been diagnosed or treated for the following conditions (pre-existing conditions)?		

_____ Cancer (Last 5 years) _____ Blood Disorders _____ Stomach Disorder _____ Psychological
_____ Alcohol / Drug Abuse _____ Heart Conditions _____ Back Problems _____ Multiple Sclerosis
_____ Muscular Dystrophy _____ Diabetes _____ AIDS Other_____

If you answered 'YES' to any of the above questions, please explain in detail below:

Name of Condition Date of Diagnosis (mm/yy) Treatment / Medication

_____

_____

_____

6. Has any employee enrolled in COBRA?_____ (If yes, please list below)

Employee Name ***Event Date*** ***Coverage Level*** *(ee, family)* ***Plan Type*** *(HMO, PPO)*

_____

_____

7. Do any employees reside in another state or region? _____ (If yes, please list below)

Employee Name **Dependent Name** **City / Zip Code**

_____

I undersigned hereby certifies that the information in this Medical Questionnaire is correct. In the event that information has been omitted, the insurance carrier may deny or limit coverage for an employee. I certify that all answers and statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind any insurance coverage.

PROSPECTIVE CLIENT

Signature:_____ Date:_____