



Office Use Only	
Company #	_____
Proposal #	_____
MASS Proposal #	_____
UW Code	_____

New Group Proposal Request Groups 51-99

(Agent must complete all sections)

Sales/Account Executive _____ Rep ID _____ Date _____ Due Date _____

SECTION 1 - GROUP NAME, ADDRESS AND PROSPECT INFORMATION					
Group Name			Street Address		
Type of Industry (required)			City	State	ZIP Code
SIC Code	Federal Tax ID (EIN)		Group Contact		Phone Number
Proposed Effective Date		Anniversary Month	Present and Past Carriers (last 3 years)		

Group's current coverage: Medical Dental Rx (for groups 51+) Life Vision Wellness

SECTION 2 - GROUP DEMOGRAPHICS AND EMPLOYER CONTRIBUTION	
<p>A. Total number of owners and employees _____</p> <p>B. Total owners and employees NOT eligible for coverage:</p> <p> Part-time or working less than 30 hrs/wk _____</p> <p> New hires within waiting period _____</p> <p> Other _____</p> <p>C. Subtotal of eligible owners and employees (A-B) _____</p> <p>D. Eligible owners and employees NOT currently enrolling:</p> <p> Waiving coverage because covered by another employer _____</p> <p> Waiving coverage because chooses no coverage _____</p>	<p>Checklist for Groups 51-99</p> <p><input type="checkbox"/> Proposal Request Form</p> <p><input type="checkbox"/> Risk Evaluation</p> <p><input type="checkbox"/> Most recent billing _____ # enrolled on bill</p> <p><input type="checkbox"/> Complete Census with waiver information</p> <p><input type="checkbox"/> Copy of current rates and benefit design</p> <p><input type="checkbox"/> Copy of renewal rates and benefit design</p> <p><input type="checkbox"/> Renewal history and reporting (if available)</p>

E. Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

F. Employer Contribution	Employee	Employee+Spouse	Employee+1 Child	Employee+Children	Family
Medical	%	%	%	%	%
Dental	%	%	%	%	%

Is employer funding any part of the deductible? No Yes If yes, how much? \$ _____ Single/\$ _____ Family
Is employer contributing to the employees HSA account? No Yes If yes, how much? \$ _____ per year or \$ _____ per month

G. Current Rates	Employee	Employee+Spouse	Employee+1 Child	Employee+Children	Family
Medical					
Dental					

H. Renewal Date _____

I. Renewal Rates	Employee	Employee+Spouse	Employee+1 Child	Employee+Children	Family
Medical					
Dental					

Comments: _____

SECTION 3 - AGENT/AGENCY INFORMATION			
Agent Name		Agency (if applicable)	
Address		City	State ZIP Code
Agent e-mail		Phone Number	Fax Number
Agent Number		Letter of Record (Y/N)	