GROUP PROPOSAL REQUEST / CENSUS INFORMATION

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UPON COMPLETION, PLEASE RETURN BY FAX TO 281 575-1149
(OR Mail to: 12219 Hoggard Dr. Stafford TX 77477)

Today's Date: _____ Requested Effective Date(s) _____

Group Name: _____

Address: _____

City: _____ County: _____ State:_____ Zip: _____

Phone Number: (___) _____ Fax: (___)

Contact Name: _____

Nature of business activity, include SIC Code if known (please be specific): _____

_____

_____

Are there any branch or divisional offices that you want covered? If so, provide location:

_____

(City, County, State, Zip)

Present Carrier: _____

Plan type: _____ How Long? _____

Summary of current benefits: _____

(Deductible/Co-insurance etc)

Renewal Date:

Current/Renewal Rates: EO $_____ ES $_____ EC $_____ Fam $

Employer Contribution: _____% of employee only rate

GENERAL HEALTH DATA:

1. Does anyone have a medical problem, or a history of frequent or recent medical treatment, been hospitalized or had surgery in the past three (3) years (i.e., cancer, diabetes, cardiovascular disease, AIDS, substance abuse, kidney disease or mental illness)?___ Yes ____ No

2. Is anyone currently pregnant? _____Yes _____ No If so, how many? _____ (Include due dates)

3. Is anyone disabled and unable to perform normal activities? _____ Yes _____ No

4. Has anyone been advised that hospitalization, surgery, or treatment is needed? ___ Yes ___ No

5. Has any employee or dependent had claims in the last 24 months over $5,000?___ Yes ___ No

6. Is anyone currently disabled or has an existing mental or physical disorder? ____ Yes ___ No

7. Are there any employees who are not actively at work because of physical or mental disability? Yes ___ No ____

If YES to any of the General Health Data questions (1-7) above, provide name and details to include medication dosage/ how often, any past or present complications, dates last seen by a doctor etc. on a separate page.

COVERAGES DESIRED

PPO 9 HMO 9 Dual Choice 9 Indemnity/Traditional 9 HSA 9 Partially Self-Funded 9
Deductible: $250 9 $500 9 $1,000 9 $_____9

Co-Insurance (in network) 100% 9 90% 9 80% 9 70% 9 50%9
Maximum out of pocket: _____
OPTIONS DESIRED:

Physician Co-Payment:	9 Yes	9 No	Maternity:	9 Yes 9 No
Supplemental Accident:	9 Yes	9 No	Wellness:	9 Yes 9 No
Prescription Card:	9 Yes	9 No	Mental/Alcohol:	9 Yes 9 No
Dental:	9 Yes	9 No	Life/AD&D Amount:	$
Disability/Long-Term	9 Yes	9 No	(Requires salary information)	
Short-Term:	9 Yes	9 No		

Employee Name	DOB	Sex	Tobacco Use (Y / N)	Dependent** Coverage (Circle one)	If to be covered		Home Zip Code	LTD/STD Salary*
					No.** Children	Spouse** DOB		
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* Salary information required for LTD and STD only.

**Dependent Coverage:: EO = Employee Only ES = Employee/Spouse (provide DOB)
ECH = Employee/Child FAM = Family Coverages (provide No. Children)

MAKE COPIES OF THIS FORM IF ADDITIONAL PAGES ARE NEEDED.