



AGENT ALLIANCE
Partners in Performance



REQUEST FOR PROPOSAL (RFP)

Phone: 888-313-9571
Fax: 269-323-8847

SHADED AREAS MUST BE COMPLETED

Date	Date Needed
------	-------------

Please complete all sections applicable to the coverage for which you are requesting a proposal. Attach census data to this RFP.

Group Name _____
 City _____ ST _____ Zip _____
 Nature of Business or SIC Code _____
 # of Employees _____
 Requested Effective Date: ____ / ____ / ____

Producer's Name as to Appear on Proposal _____
 Agency Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone Number () _____
 Fax Rates to: () _____ Attn: _____
 E-mail Rates to: _____

Current Carrier(s) _____

CLASS DESCRIPTION - employees in the classes below are to be quoted for the benefits listed at right.

Employer Contribution → _____ %
 Current Rate → _____
 Renewal Rate → _____

VOLUNTARY DENTAL

- BASIC**
- PREMIER**
 - ORTHODONTIA** (elected at group level – for groups with 3 or more employees)
 - ORTHODONTIA TAKEOVER** Yes No
- TAKEOVER - PRIOR PLAN** (for 3 or more)

Comments or Special Requests: _____

LIFE AD&D

FLAT AMOUNT
 \$ _____ on all Full-time Employees
 Multiple of Earnings
 _____ x Earnings on all Employees to max of \$ _____
 FLAT AMOUNT
 (List benefits below)

_____ %
 _____ Per \$1000
 _____ Per \$1000

LIFE REDUCTIONS
 35% at 65, Terminate at 70 or Retirement (Groups of 2 to 9)
 35% at 65, 50% at 70, 75% at 75. Terminate at Retirement (Groups 10+)
 Other _____

Extended Death Benefit (2-9 Employees)
Waiver of Premium (10+ Employees)
 Dependent Life Amount
 Spouse \$ _____
 Child(ren) \$ _____
 Life Claims Experience Attached (Groups 150+)

VOLUNTARY?
 Yes No

STD

FLAT AMOUNT
 \$ _____ / week on all Full-time Employees
 Percent of Earnings
 _____ % of Earnings to a max benefit of \$ _____ / week
 CLASS PLAN
 (List benefits below)

_____ %
 _____ Per \$10
 _____ Per \$10

SHORT TERM DISABILITY
 _____ day(s) accident
 _____ days sickness
 _____ weeks
 1/8/13, or 1/8/26 (Standard)
 STD Claims Experience Attached (Groups 100+)

VOLUNTARY?
 Yes No

LTD

PERCENT OF EARNINGS
 \$ _____ % of Earnings to \$ _____ max monthly benefit on all Full-time Employees (STANDARD)
 CLASS PLAN
 (List benefits below)

_____ %
 _____ Per \$100
 _____ Per \$100

ELIMINATION PERIOD
 90 Days 180 Days
 120 Days Other _____

BENEFIT INTEGRATION
 Primary and Family (Standard)
 Primary Only

BENEFIT DURATION
 To Age 65 RBD
 5 Year 2 Year

OWN OCC DEFINITION
 2 Yr 3 Yr 5 Yr
 To 65
 LTD Claims Experience Attached (Groups 200+)

VOLUNTARY?
 Yes No