

101⁺ REQUEST FOR QUOTE

Submit this form and completed census to
your dedicated Account Executive
or submit by email to sales@dickerson-group.com



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Proposal Information

Coverage Types: _____
Proposal Due: _____
Funding Type: ☐ Fully Insured ☐ Level-Funded ☐ Self-Funded

Group Information

Company/Group Name: _____
Address: _____
City: _____
State: _____ ZIP Code: _____
DBA: _____ Phone: _____
Nature of Business: _____
SIC Code: _____ Years in Business: _____
Effective Date: _____ Waiting Period: _____
(non-COBRA) Eligible Employees: _____
COBRA Employees: _____
Employees on Leave: _____
Common ownership with other companies? ☐ Yes ☐ No

Broker Information

Date: _____
Broker Firm Name: _____
Producer Name: _____
Broker Address: _____
City: _____
State: _____ ZIP Code: _____
Phone: _____ Fax: _____
Email: _____
Broker of Record? ☐ Yes ☐ No
Broker Commission: Medical: _____ Ancillary: _____
Please quote with GA override, where applicable

Medical Coverage

5-Year Carrier History			
	Carrier Name	Type of Coverage	Period Insured or # of Years
1			
2			
3			
4			

If Kaiser is Present: ☐ Kaiser Will Remain ☐ Total Replacement

Match current plan designs & networks? ☐ Yes ☐ No

Quote/specific plan design(s) - please list: _____

Large claims: _____

Carriers to be Quoted (Call for Details)

☐ Anthem Blue Cross ☐ Aetna ☐ Blue Shield ☐ Cigna ☐ Kaiser ☐ United Healthcare

Plans to be Quoted

☐ HMO ☐ PPO ☐ HSA ☐ POS

Medical employer contribution employee: _____

Medical employer contribution dependent: _____

Please attach current benefit summaries and current benefit renewal(s) for all requested coverages. Census and medical large claims report (if available) are also required.

Ancillary Coverage

- ☐ **Match all current benefit plans/networks**
- ☐ **Quote specific plan design(s) - please list for each coverage type below**

☐ **Life:**

Amount: _____ Basis: _____

Life employer contribution - employee: _____

Life employer contribution - dependent: _____

☐ **Dental:**

Current carrier: _____

Requested plans: _____

Dental employer contribution - employee: _____

Dental employer contribution - dependent: _____

☐ **Vision:**

Current carrier: _____

Current benefits: **Please attach benefit summary(ies)**

Current rates: _____

Requested plans: _____

Vision employer contribution - employee: _____

Vision employer contribution - dependent: _____

☐ **STD/LTD:**

Current carrier: _____

Requested plans: _____

☐ **Worksite:**

Current carrier: _____

Requested plans: _____

RFP Strategy

Employer Questions

Yes/No

- | | |
|---|----|
| 1. Has any insured received medical benefits in excess of \$15,000 in the last 12 months?
If YES , please provide details: _____ | No |
| 2. Are there any disabled participants?
If YES , please provide #: _____ | No |
| 3. Are there any catastrophic or other serious medical conditions, pregnancies, or coverage of members not actively at work, or currently hospital-confined?
If YES , please provide details: _____
For pregnancies, please provide #: _____ | No |
| 4. Are all employees covered by workers' compensation insurance?
if NO , please provide # not covered: _____ | No |
| 5. Has any owner or principal filed bankruptcy within the past seven years, or known to be planning to file bankruptcy? | No |
| 6. Does the employer reimburse employees for any part of their normal out-of-pocket costs? (copays, deductibles, coinsurance, etc.) | No |