DirectBenefits

Request for Proposal (RFP)

Date:_____Date Needed:_____

Group Name: _____

City:_____State:_____Zip Code: _____

Nature of Business or SIC Code: _____Requested Effective Date:_____

# of Eligible Employees*:_____Are Employees 100% Family Related? ____ Yes ____ No

Producer's Name:_____

Phone Number_____E-Mail Address:_____

Current Coverage Information: ***Include a copy of current plan design and renewal rates, if available*

- # of Employees Enrolled_____
- Current Rates: EE_____ EE+Spouse_____EE+Child(ren)_____ Family_____
- Renewal Rates: EE_____ EE+Spouse_____EE+Child(ren)_____ Family_____
- Current or Requested Plan Design:_____

_____

Dental

❑ Employer Paid
❑ Voluntary

Annual Max: ❑ $1000 ❑ $1500 ❑ $2000 ❑ $3000 ❑ $5000

Deductible:

❑ $100 Lifetime Deductible
❑ $50/$150 Calendar Year Deductible
❑ $25/$75 Calendar Year Deductible
❑ $0/$0 Deductible

Additional Options:

❑ Endo/Perio to Basic
❑ Composite (white)Fillings Upgrade
❑ Child Ortho
❑ Adult and Child Ortho
❑ Other Options _____
❑ No Waiting Periods
❑ 2 year rate guarantee

Vision

❑ Employer Paid
❑ Voluntary

Frequency

❑ Materials Only
❑ 12/12/24
❑ 12/12/12

Co-Pay

❑ $10/$0
❑ $10/$10
❑ $10/$25

❑ Other Options_____

*For Groups with 100+ eligible employees, please send/email census to: agentsupport@directbenefits.com

Request for Proposal (RFP)

Date: _____ Date Needed: _____

Group Name: _____

City: _____ State: _____ Zip Code: _____

Nature of Business or SIC Code: _____

No. of Employees: _____ Requested Effective Date: _____ ☐ Non-Contributory ◯ Contributory ◯ Voluntary

Comments or Special Request: _____

Please complete all sections applicable to the coverages for which you are requesting a proposal.

Producer's Name as to Appear on Proposal: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Group Census Information: **Are Employees 50% Family Related?** ____ Yes ____ No

	Age/DOB	Gender	Salary/ Wages	Occupation
1.				
2.				
3.				
4.				
5.				

	Age/DOB	Gender	Salary/ Wages	Occupation
6.				
7.				
8.				
9.				
10.				

For groups with 10+ eligible employee, please send/email a complete census to: AgentSupport@DirectBenefits.com

☐ **Life/AD&D**

Flat Amount: $_____ on all Full-time Employees

Multiple of Earnings: _____X Earnings on all Employees to max of $_____

Class Plan (List benefits below)

☐ **STD**

Flat Amount: $_____/week on all Full-time Employees

Percent of Earnings: _____% of Earnings to a max benefit of $_____/week

Short Term Disability: 1st day accident
8th day sickness

☐ 13 Weeks ☐ 26 Weeks

☐ **LTD**

Percent of Earnings: _____% of Earnings to $_____ max monthly benefit on all Full-time EEs (STANDARD)

Elimination Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days