

Group Proposal Request Form

Fax to 231-922-0129 or Email to karen@wrightinsurancegroup.com

Company Name _____

County _____

ZIP Code _____

Nature of Business or SIC Code – if known _____

Total # Full Time Employees (30+ hours per week) _____

Total # Employees Full & Part Time _____

Do owners need on the job protection **NO** **YES** If yes, Specify whom _____

Current Coverage **NO** **YES** If yes, list current carrier _____

Agent Name _____

Agent Email Address _____

Special Requests _____

Effective Date _____

Note: Due to the new privacy legislation please do not refer to employee name; use ages only, not DOB

	Age	Gender	Coverage					# of Children	Dental	Cobra
1		M F	EE	ES	EC	EF	LO		Y N	Y N
2		M F	EE	ES	EC	EF	LO		Y N	Y N
3		M F	EE	ES	EC	EF	LO		Y N	Y N
4		M F	EE	ES	EC	EF	LO		Y N	Y N
5		M F	EE	ES	EC	EF	LO		Y N	Y N
6		M F	EE	ES	EC	EF	LO		Y N	Y N
7		M F	EE	ES	EC	EF	LO		Y N	Y N
8		M F	EE	ES	EC	EF	LO		Y N	Y N
9		M F	EE	ES	EC	EF	LO		Y N	Y N
10		M F	EE	ES	EC	EF	LO		Y N	Y N
11		M F	EE	ES	EC	EF	LO		Y N	Y N
12		M F	EE	ES	EC	EF	LO		Y N	Y N
13		M F	EE	ES	EC	EF	LO		Y N	Y N
14		M F	EE	ES	EC	EF	LO		Y N	Y N
15		M F	EE	ES	EC	EF	LO		Y N	Y N
16		M F	EE	ES	EC	EF	LO		Y N	Y N
17		M F	EE	ES	EC	EF	LO		Y N	Y N
18		M F	EE	ES	EC	EF	LO		Y N	Y N
19		M F	EE	ES	EC	EF	LO		Y N	Y N
20		M F	EE	ES	EC	EF	LO		Y N	Y N

EE=Employee Only ES=Employee Spouse EC=Employee Children EF=Employee Family LO=Life Only

Answer the following questions for employees and their dependents. Is/has any employee or dependent:

NO **YES**

 Incurred medical claims of more than \$5,000 during the past 12 months? If yes, give reasons:

 Within the past 6 months been disabled or hospital confined? If yes, give reasons:

 Currently pregnant? If yes, give due date: _____

 Been diagnosed as having or received treatment in the past five years for:

- a. Cancer or malignancy
- b. Heart disorder, heart disease or stroke
- c. Acquired immune deficiency syndrome (AIDS) or AIDS Related Complex (ARC)
- d. Received treatment for drug abuse or chemical dependency
- e. Received treatment for alcohol abuse
- f. Diabetes (insulin dependent)

Proposed rates are not binding and final approval will only be given following receipt and approval of a properly completed application. Any changes in group composition or medical history may require additional evaluation. AMS, Assurant Health, and IAC comply with all state and federal mandated requirements regarding the acceptance and issuance of Small Group medical coverage.

Rates are based on medical history disclosed on this form. If circumstances change, a new quote must be requested.

I hereby certify that to the best of my knowledge, the information provided herein is complete and true.

AGENT SIGNATURE _____ DATE _____