REQUEST FOR PROPOSAL
NY ANCILLARY AND NON-NY MEDICAL

Name of Company			Type of Company	
Address			**Date**	
City	**State**	**Zip**	**Tel #**	**Fax #**

MAJOR MEDICAL:			
In Network Co-pay	**Out of Network Deductible**	**Co-Insurance**	**Drug Card Co-pay**

LIFE INSURANCE:			
Employee Amount	**Flat Amount**	**1x Salary**	**Other**
Are child(ren) and spouse eligible? If yes check all that apply and include amount			
Spouse		Child(ren)	

DENTAL:

Are you currently covered?	❒ Yes	❒ No		
Comprehensive	_____	**Voluntary**	_____	
Maximum Benefit	❒ $1,000	❒ $1,500	❒ $2,000	
Deductible	❒ $50	❒ $100		
Do you wish deductible to be waived for preventative?	❒ Yes	❒ No		
Ortho	❒ Yes	❒ No		

GROUP LTD:	
Benefit/Month	**Elimination Period**

If you selected LTD to be quoted, please answer questions 1-4	
1. How long has the business been in existence?	
2. How many Insurance Carriers have you had in the last five years?	
3. Are any employees currently out of work because of a medical condition or are any eligible dependents currently hospital confined?	
4. During the past twelve months, how many active employees or their eligible dependents had medical expenses in excess of $3,000, but less than $10,000?	❒ Less than $10,000 ❒ $10,000 or greater