Request for Proposal

Name of Prospect:	**Proposed Effective Date:**	☐ Essential Bronze Plus Program	☐ HSA Compatible GAP
		☐ Major Medical	☐ GAP
Prospect's Legal Address:	**Number Eligible Employees:**	☐ Limited Medical	☐ Dental
		☐ E-MEC	☐ Vision
		☐ Section 125	☐ MEC
Industry (please be specific):	☐ Corporation ☐ Partnership ☐ Association ☐ MEWA ☐ Trust ☐ Union ☐ PEO ☐ Sole Proprietorship		
List Other Locations Including Zip Codes:	☐ Other (Specify)		

CENSUS REQUIRED FOR GAP & MAJOR MEDICAL QUOTES - Please attach a census including age (or date of birth), Gender, Zip Code and current Medical tier.

Writing Producer/Who commissions will be payable to: **Tax ID Number:** **Phone:**

Fax:

Email:

Name of Group Representative:

Included a copy of the current plan design: ☐ Yes ☐ No

Plans requested:

Please list current and renewal rates:

What employer contributions are anticipated per employee per month? (please circle one)

0% **25 %** **50%** **100 %** **Not sure yet**

Please describe any other medical benefits the employer makes available to this group of employees or that the employer may be interested in:

Additional Information:

Producers Signature: **Date:**

Submit Proposal requests to:

OptiMed's Proposal Department

Proposal@optimedhealth.com

Or Fax to: 215-968-6301

Form #1001