Request for Proposal (RFP)

Please fill out the following form. Once completed please send us a copy in one of the following ways:
Email | agentsupport@directbenefits.com Fax | 651-649-3502

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 _____ **Email** _____

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

- ○ $1,000 ○ $1,500 ○ $2,000
- ○ $3,000 ○ $5,000
- ○ *$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
- ○ No Waiting Periods
- ○ 2 year rate guarantee
- ○ Adult and Child Ortho
- ○ Other Options

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 50+ members please submit a census for custom quoting to AgentSupport@DirectBenefits.com or call us with questions at (800) 620-5010 x 5

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Date _____ **Date Needed** _____

Group Name _____

City _____ **State** _____ **Zip Code** _____

Nature of Business or SIC Code _____ **Requested Effective Date** _____

# of Eligible Employees* _____ ○ Employer Paid ○ Partial Employer Contribution ○ Voluntary

Comments or Special Requests _____

_____

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** _____

Email Address _____

Group Census Information

Are Employees 50% Family Related? ○ Yes ○ No

	Age/ DOB	Gender	Salary/ Wages	Occupation		Age/ DOB	Gender	Salary/ Wages	Occupation
1					6				
2					7				
3					8				
4					9				
5					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 a max of $

Class plans (list benefits below)

LTD

Percent of Earnings % of Earnings to max benefit of /month

Elimination Period

○ 60 days ○ 90 days ○ 180 days

STD

Flat Amount: $ /week on all Full-time employees

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

Short Term Disability Benefits Duration

○ 13 weeks ○ 26 weeks

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