REQUEST FOR PROPOSAL FORM
LARGE GROUPS (101+ EMPLOYEES)

BROKER INFORMATION	BUSINESS/GROUP INFORMATION
BROKER NAME	COMPANY NAME
AGENCY NAME	DBA
PHONE FAX	EFFECTIVE DATE REQUESTED PROPOSAL DUE DATE
ADDRESS CITY/ZIP	NATURE OF BUSINESS
E-MAIL	DOES THE GROUP OFFER CROSS-BORDER INSURANCE? ☐ YES (PLEASE IDENTIFY IN CENSUS) ☐ NO
BROKER LICENSE NUMBER	CURRENT CARRIER(S) *(PLEASE ATTACH RENEWAL RATES)* MEDICAL: ______________________ DENTAL: ______________________ VISION: ______________________
COMMISSION REQUESTED	
BROKER OF RECORD? ☐ YES ☐ NO	# OF ELIGIBLE EE'S __________ # OF ENROLLED EE'S __________
REASON FOR SHOPPING: ☐ REDUCING COSTS ☐ IMPROVE BENEFITS ☐ MARKET CHECK ☐ OTHER __________	ELIGIBLE EMPLOYEES ARE PERMANENT, ACTIVE, FULL-TIME EMPLOYEES WORKING A MINIMUM OF 30 HOURS PER WEEK. THE FOLLOWING CLASSIFICATIONS ARE NOT ELIGIBLE: EMPLOYEES WORKING LESS THAN 30 HOURS PER WEEK, LEASED EMPLOYEES, SEASONAL EMPLOYEES, 1099, UNION, BOARD MEMBERS, RETIREES, COBRA PARTICIPANTS OR SURVIVING SPOUSES.
HOW DID YOU HEAR ABOUT US?	EMPLOYER MEDICAL CONTRIBUTION FOR **EMPLOYEE**:_____% OR $_____ EMPLOYER MEDICAL CONTRIBUTION FOR **DEPENDENTS**:_____% OR $_____

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Please send client's **Billing Contact's** information and **E-mail Address** to **billing@mediexcel.com**.

NRM 061519

Please return completed form along with census and current carrier rates to: rfp@mediexcel.com