

Health Plus Consulting Services, Inc.

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REQUEST FOR GROUP PROPOSAL ** In addition, please print and fill in a [Census](#).

Name of Group _____ Requested Effective Date _____

Address _____ City _____ State ____ Zip _____

Phone _____ Fax _____ Group Industry _____

Number of Full-Time Employees _____ Number of Employees Presently Insured _____

EE (Only) _____ EE/Spouse _____ Family _____ EE/Child(ren) _____

Current Carrier _____ Waiting Period _____

Current Benefits _____

% of Employer Contributions: Employee _____ % Dependents _____ %

Are there any employees covered under COBRA? _____ If yes, how many _____

1. Were there any employees or dependents who incurred medical expenses of \$5,000 or more during the last 12 month period? YES _____ NO _____

2. Are there any physically handicapped dependents over age 19 covered by the current carrier? YES _____ NO _____

3. Are there any employees or dependents to be covered under the proposed coverage who currently have serious health problems? (For example, but not limited to: cancer, heart trouble, neuromuscular disorder, AIDS, kidney trouble, paralysis or diabetes) YES _____ NO _____

4. Are there any active maternity cases? YES _____ NO _____

5. Is there anyone on disability or on waiver of premium status? YES _____ NO _____

6. If the answer to any of the above is YES, please give details including:

NAME: _____

Health Conditions (Dates)/Type of Treatment and Charges: _____

Name of Agent

Signature of Agent

Date