

Today's Date _____

REQUEST FOR PROPOSAL

Group Name

Contact Name _____

Address _____

Phone Number _____

Fax Number _____

Business Type _____

Effective Date _____

Please quote the following:

- Medical
 Dental
 Life
 LTD
 Vision
 Other _____

Special Requests: _____

Employee Name	Sex	Age	Coverage* (see key below)	# of Children
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

MEDICAL INFORMATION

To the best of your knowledge, please answer following questions and provide details on separate page:

- A. Any employee or dependent currently pregnant? Yes No
- B. Any employee or dependent have any claims in past year over \$5,000? Yes No
- If Yes, please explain:
- C. Any employee or dependent have any serious ongoing medical problems? Yes No
- D. Any employee or dependent currently on Cal-COBRA or COBRA? Yes No How many? _____

CURRENT CARRIER INFORMATION

Current Carrier _____

PLEASE PROVIDE COPY OF CURRENT BILLING

Other Health Carriers within past 5 years _____

Employer Contribution: Employee _____ Dependent _____

Please FAX Complete Proposal to:

TSM INSURANCE

(209) 524-6846



Or Mail to:
TSM Insurance & Financial Services

1317 Oakdale Road #910
 Modesto, CA 95355

Key:
 *E=Employee ES=Married
 EC=Employee + Child(ren) ESC=Family

Please call (209) 524-6366 if you do not receive total amount of pages indicated.