

REQUEST FOR BENEFIT PLAN PROPOSAL(S)



MANAGED BENEFITS
INCORPORATED

TO: Managed Benefits, Inc.
FAX: 804.285.1202
E-Mail: contact@managedbenefits.com

A broker/consultant will contact you promptly to discuss the types of plan design features, networks, etc., you wish to consider and other strategies for marketing your plans.

Company Name:

Headquarters Address:

Locations:

City:

State:

Number Employees:

Total Number of Employees

Contact Name and Title:

Contact Phone:

Contact E-mail:

Contact Fax:

**Number of years in
business:**

Nature of business:

Next page>>>>>>

CURRENT PLANS AND CARRIERS

PLAN	Carrier or Administrator	Years with carrier	Do you wish to market this plan? (X = Yes)	Renewal Date
Health				
Rx Drug				
Dental				
Vision				
Life and AD&D				
Short Term Disability				
Long Term Disability				
Flexible Spending Accounts				
Section 125				
EAP				
401(k)				

Waiting Period for employees to be eligible for coverage?

HEALTH PLAN

Type of plan(s) (ex: HMO, PPO, POS, Indemnity):

Employer Contributions for coverage:

Classes of employees covered:

Full-time hours:

Current Monthly Rates	Employee	E + Spouse	E + Child	E + Children	Family
Plan 1:					
Plan 2:					

DENTAL PLAN

Type of plan(s) (ex: DHMO, PPO, Indemnity):

Employer Contributions for coverage:

Classes of employees covered:

Full-time hours:

Current Monthly Rates--	Employee	E + Spouse	E + Child	E + Children	Family
Plan 1:					
Plan 2:					

LIFE AND AD&D

Level of coverage:

Employer Contribution:

Classes of employees covered:

Full-time hours:

Rate per \$ 1,000

SHORT TERM DISABILITY

Level of coverage:

Employer Contribution:

Classes of employees covered:

Full-time hours:

Rate per \$ 10

LONG TERM DISABILITY

Level of coverage:

Employer Contribution:

Classes of employees covered:

Full-time hours:

Rate per \$ 100

TO: Managed Benefits, Inc.
FAX: 804.285.1202
E-Mail: contact@managedbenefits.com

THANK YOU!