Word&Brown.

NEVADA SMALL GROUP

PROPOSAL REQUEST

Email quotes to nevadaquotes@wordandbrown.com or fax to 800.700.6744

BROKER INFORMATION

Broker Name: _____

Agency: _____

Address: _____

City: _____ , NV Zip _____

☐ Check if new address

Broker Code (if known): _____

Broker License Number: _____

Phone: _____ Fax: _____

Email Address: _____

BUSINESS/GROUP INFORMATION REQUIRED INFORMATION

Company Name:

Company Zip: Company County:

Nature of Business:

Number of Full-time employees (30+ hours/week):

Percent of costs to be paid by Employer:

_____ % of Employee Costs _____ % of Dependent Costs

Type of Employees to be quoted:

☐ All ☐ Management ☐ Hourly ☐ Salary ☐ Non-Union

Desired Effective Date: ___/___/___

1. Company Structure:
   ☐ Sole Proprietor ☐ Corporation ☐ LLC ☐ Partnership
   ☐ Other _____
2. More than one location? ☐ Yes ☐ No
   If yes, where? _____
3. Any employees paid by commission (and/or) paid as independent contractors? (FORM 1099) ☐ Yes ☐ No
   Most current state tax form available? ☐ Yes ☐ No
   How many weeks payroll? _____
4. Any COBRA participants previously employed by you? (if yes, indicate Zip Code on Census located on next page) ☐ Yes ☐ No
5. Employees living Out-of-State? ☐ Yes ☐ No

PROPOSAL TYPE

☐ **Summary Proposal** — Summary of All Plans or Selected Carriers
☐ **Custom Proposal** — Select Plans for Benefit and Rate Details
☐ **Employee Choice** — Assign Plans to Employees for Blended Rate

Product Type

☐ Medical (All)
- ☐ Aetna Funding Advantage *(10+)*
- ☐ Anthem Blue Cross Blue Shield
- ☐ Cigna *(25+)*
- ☐ EDIS
- ☐ National General
- ☐ Prominence

☐ Dental
☐ Vision
☐ Life*
☐ LTC*
☐ LTD*
☐ STD*

Medical Benefit Type

☐ All ☐ HRA ☐ PPO
☐ HMO ☐ HSA ☐ POS

PLAN DESIGN - SELECTIONS FOR PPO PLANS

☐ All Plans
☐ Specific Range _____

***NOTE:** Colonial Worksite Ancillary Products will be offered to all group members at open enrollment. Products to be offered (may select minimum 2 or all):

☐ Disability ☐ Critical Illness
☐ Accident ☐ Term Life
☐ Cancer ☐ Whole Life

Initial Here _____ ONLY If Group wishes to REFUSE Colonial worksite Product Offerings.

CURRENT COVERAGE INFORMATION

Current Health Plan: _____

Current Premium: _____

Current Plan Type: ☐ HMO ☐ PPO ☐ EPO ☐ HSA ☐ POS

Are you with a PEO? ☐ Yes ☐ No

Does group have current dental coverage? ☐ Yes ☐ No

If yes, number of years: _____ % participation: _____

DELIVERY OPTIONS

☐ **Pick-up** - Las Vegas
☐ **Email to:** _____
☐ **Mail complete proposal**
☐ **Fax to:** _____
☐ **Have Representative call me at:** _____

Fax completed census to:

Las Vegas
7201 West Lake Mead Blvd., Suite 220,
Las Vegas, NV 89128
800.606.4996
Fax 800.700.6744

Company Name: _____

Broker Name: _____

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Fill in the columns below. Fields marked with an asterisk (*) are mandatory.

1. Enter the Employee first, then every other family member (spouse and children) to be covered on subsequent lines. The Employee ID should be entered sequentially and the same number should be used for each family member. Each person's Date of Birth is mandatory for quoting.
2. After the full family is entered, the next Employee should be started on the following lines. Do not skip a line between employees.

Covered Member Key	
E or 1 =	Employee
S or 2 =	Spouse/Domestic Partner
D or 3 =	Other Dependents

PLEASE NOTE: Every person to be covered is rated individually. Rates vary by age and any change in the date of birth of an employee, spouse or dependent will cause the quoted rates to be different. Any change to the ZIP code and/or number of dependents can also cause the rates to be different.

CENSUS

Employee ID	Covered Member Code (See Key above) *REQUIRED*	Last Name	First Name	Gender (M/F)	Date of Birth (mm/dd/yyyy) *REQUIRED*	ZIP Code Employee Only *REQUIRED*	EE on COBRA? (Y/N)
1	E	Doe	John	M	09/19/1968	90000	N
1	S	Doe	Jane	F	10/07/1969	90000	N
1	D	Doe	Tom	M	12/15/2000	90000	N