Word&Brown.

CALIFORNIA

PROPOSAL REQUEST

Email quotes to wabquoting@wordandbrown.com

BROKER INFORMATION

Broker Name: _____

Agency: _____

Address: _____

City: _____ , CA 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
☐ **California*Choice***
☐ **Choice Builder**

SHOP plan will automatically generate with Summary Proposals and are available upon request for Custom and Employee Choice Proposals.

Products ☐ All

☐ Medical

Plan Designs
☐ All ☐ PPO
☐ HMO ☐ POS
☐ HRA ☐ Specific Plans
☐ HSA (indicate below)

☐ Dental ☐ Prior Coverage

Plan Designs
☐ DHMO
☐ EPO
☐ Indemnity
☐ DPO

☐ Vision
☐ Life*
☐ LTC*
☐ LTD*
☐ STD*

Specific Plans 1. _____
2. _____
3. _____

***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** (check location)
☐ Orange ☐ San Jose
☐ San Diego ☐ Inland Empire
☐ Los Angeles

☐ **Email to:** _____

☐ **Mail complete proposal**

☐ **Fax to:** _____

☐ **Have Representative call me at:** _____

Fax completed census to office nearest you:

Orange
721 South Parker Street
Orange, CA 92868
Fax 714.953.9404

Inland Empire
3633 Inland Empire Blvd. Ste. 525
Ontario, CA 91764
Fax 909.945.3339

Los Angeles
801 North Brand, Ste. 900
Glendale, CA 91203
Fax 800.355.9711

Northern California
1737 North First Street, Ste. 680
San Jose, CA 95112
Fax 800.437.5925

San Diego
3131 Camino Del Rio North, Ste. 820
San Diego, CA 92108
Fax 619.299.2070

CENSUS

Company Name: _____ **Broker Name:** _____

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.

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.

COVERED MEMBER KEY		
E or 1 = Employee	S or 2 = Spouse/Domestic Partner	D or 3 = Other Dependents

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

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