AgBenefits
PO Box 50850, Amarillo, TX 79159-0850
(806) 731-4740 | Fax: (806) 350-7886

Request for Insurance Proposal

Company Name: ________________________________
Company City/State/Zip Code: ________________________
SIC Code: ________________________________
Proposed Effective Date: ________________________

Contact Name: ________________
Phone Number: ________________
Email: ________________________

Current Carrier: ________________________ Effective Date: ____________________
(*if less than two years with above carrier, who was the prior carrier and for how long?)* ____________

Current rates: ________________________________
(and renewal rates, if available): ________________________

Current Benefits: ________________________________
(please attach a copy of the current benefit summary) ________________

Employee Census

NAME	GENDER	DOB	COVERAGE*	SPOUSE DOB	# of CHILDREN

*Coverage Key – EE=Employee only; ES=Employee plus Spouse; EC=Employee plus child(ren); EF=Employee plus spouse & child(ren)

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Risk Information For:

Company Name: ______________________________________
____

Number of…

_______ Employees or dependents in this group who are pregnant (Indicate due Date) _________________

_______ Employees or dependents in this group who are disabled or not actively at work.

_______ Employees or dependents in this group who are anticipating treatment in excess of $5,000 in the next twelve months.

_______ Employees or dependents in this group who incurred $5,000 or more in claims during the past twenty four (24) months.

_______ Employees or dependents in this group who have knowledge of or; during the past twenty four (24 months, received treatment for disease, disorder or ailment of: Blood, Immune System, Cancer, Diabetes, Heart, Kidney, Skeletal System, Respiratory System, Psychological, Alcohol or Drug Abuse

Provide details to questions above in the area below. For past claims, provide diagnosis, prognosis, course of treatment (if applicable) and the approximate claim amount for all individuals. Please use another sheet if necessary.

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If you have monthly groups claim sand enrollment data, please supply that information.
(Note HB 2015 requires fully insured carriers to supply claims information to the employer, upon request)

______________________________________ ______________________
Completed By Date