SeaGate Benefits Administrators, Inc.

Request For Group Proposal

*Contact Name*_______________________________ *Today's Date*_________________ *Phone #*_____________________ *Fax #* ______________ _____
Name of Group: __________________________________ *Address:*________________________ *What Effective Date are you looking for?* ___________

Medical	Dental	Vision	STD	LTD:	Life AD & D:	Other
Plan Design? HMO PPO POS	**Voluntary?** **OR** **ER Paid?**	**Voluntary?** **OR** **ER Paid?**	**Voluntary?** **OR** **ER Paid?**	**Voluntary?** **OR** **ER Paid?**	**Life Flat Amount?** $	
Deductible? HSA? $	**Traditional** **OR** **PPO?**	**Traditional** **OR** **PPO?**	**Duration?** 13 26	**Duration?** SSNRA Other ________	**Life Graded?** Class 1 $__________ Class 2 $__________ Class 3 $__________	
Co-insurance %?	**Deductible?** **$**	**Deductible?** **$**	**Elimination Period?** 1/8 8/8 15/15	**Elimination Period?** 90 180	**AD & D Flat Amount?** $	
Office Co-pay? $	**Reimbursement?** Preventive_____% Basic ______% Major ______% **(i.e. 100/80/50)**	**Copays:** $	**Benefit %?** 60% 66.7% 70%	**Max Monthly Benefit?** $	**AD & D Graded?** Class 1 $__________ Class 2 $__________ Class 3 $__________	
Prescription?	**Annual Max?** $ _______________ **U & C?** 70th 80th 90th	**Reimbursement?** 12/12/12 12/12/24 12/24/24	**Max Weekly Benefit?** **$**		**Cut Back?** Age 65 Age 70	
Misc	**Orthodontic?** Yes / No **Life Time Max?** $	**Misc**	**Misc**	**Misc**	**Misc**	

Do you currently have a plan in Place? If yes please give details below.

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This is for Quoting Purposes Only. Please Complete All Forms and Return To SBA Fax # 419.517.7406 or Call 419.517.7079 ext. 320. Thank You!