Please download first and then complete in Adobe Acrobat. Don't use your web browser!
Send completed RFP to Jamie Shawa at (517) 371-7233 (fax) or jshawa@michamber.com

Request for Proposal(s)

Date of submission: ____________ Quote(s) need by date: ____________ Agency: __________________
Producer: ____________Producer phone: ____________Producer email: _______________________

I Basic Account Information

Legal Name: ____
DBA __________________________ Form of Business: _____________________ # of Locations: ____
FEIN #: ____________ Total EE's: _________ Part-Time EE's: _________ Eligible EE's: ____________
Corporate Address: ____
Phone: ________________ Fax: ________________Website: ____________________________________
SIC Code: ______________ NAICS Code: _______________ Payrolls/Year: ______________
Description of Operations: ____

II *CURRENT* Benefit Plan Information

Complete below fields for lines of coverage you wish to be quoted ONLY.
Please include current benefit summaries for lines you wish quoted.

Check Box: **Check Box:**

Group Dental: ☐ Carrier: _________________ Renewal Date: _________
~Does employer contribute at least 50% of the Employee-Only premium? ☐ **YES** ☐ **NO**
Group Vision: ☐ Carrier: _________________ Renewal Date: _________
~Does employer contribute at least 50% of the Employee-Only premium? ☐ **YES** ☐ **NO**
Group Life: ☐ Carrier: _________________ Renewal Date: _________
~Does employer contribute at least 50% of the Employee-Only premium? ☐ **YES** ☐ **NO**
Group STD: ☐ Carrier: _________________ Renewal Date: _________
~Does employer contribute at least 50% of the Employee-Only premium? ☐ **YES** ☐ **NO**
Group LTD: ☐ Carrier: _________________ Renewal Date: _________
~Does employer contribute at least 50% of the Employee-Only premium? ☐ **YES** ☐ **NO**

Other Worksite Benefits currently offered?

____
____
____
____
____
____
____
____

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III Requested Quotes

Group Dental Quotes Requested

Desired Effective Date of Coverage: ☐

Insurance Carrier — **Request**

All Carriers ☐

- -Delta Dental ☐
- -AlwaysCare ☐
- -MetLife ☐
- -Lincoln Financial ☐

Plan Specifications

Quote same as current ☐
(Must include current benefit summary)

100% Employer-Paid ☐

100% Voluntary ☐

Employer pays ≥ 50% of EE cost ☐

DHMO Only ☐ PPO Only ☐ BOTH ☐

Alternate Plan Designs Requested

(Preventative / Basic / Advanced)

		EHB			EHB
100/80/80	☐	☐	**80/80/50**	☐	☐
100/80/50	☐	☐	**80/50/50**	☐	☐
100/50/50	☐	☐	**50/50/50**	☐	☐

Other: ☐

(Annual Maximums Tiers 1-3)

Annual Max. Tiers 1-3 $1,000 ☐

Annual Max. Tiers 1-3 $1,500 ☐

Annual Max. Tiers 1-3 $2,000 ☐

Annual Max. Tiers 1-3 OTHER: ☐

(Lifetime Maximums – Orthodontia)

Lifetime Max. Ortho N/A ☐

Lifetime Max. Ortho $1,000 ☐

Lifetime Max. Ortho $1,500 ☐

Lifetime Max. Ortho OTHER: ☐

Group Vision Quotes Requested

Desired Effective Date of Coverage: ☐

Insurance Carrier — **Request**

All Carriers ☐

- -VSP ☐
- -Always Care ☐
- -MetLife ☐
- -EyeMed ☐
- -Lincoln Financial ☐

Plan Specifications

Quote same as current ☐
(Must include current benefits summary)

100% Employer-Paid ☐

100% Voluntary ☐

Employer pays ≥ 50% of EE cost ☐

Alternate Plan Designs Requested

(Exam/Lenses/Frames) Months		*(Copays: Exam/Lenses)* Per Visit	
12/12/12	☐	**$10/$10**	☐
12/12/24	☐	**$10/$25**	☐
12/24/24	☐	**$20/$25**	☐
24/24/24	☐	**$25/$25**	☐

Other: ☐ **Other:** ☐

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MICHIGAN CHAMBER Services

Group Life Quotes Requested

Desired Effective Date of Coverage: ☐

Insurance Carrier	**Request**
All Carriers	☐
-MetLife	☐
-AlwaysCare	☐
-Reliance Standard	☐
-Lincoln Financial	☐

Plan Specifications

Quote same as current *(Must include current benefits summary)*	☐
100% Employer-Paid	☐
100% Voluntary	☐
Employer pays ≥ 50% of EE cost	☐

Alternate Plan Designs Requested

$10,000	☐	**$50,000**	☐
$15,000	☐	**$20,000**	☐
1X Salary	☐	**2X Salary**	☐

Highest Guaranteed Amount: ☐

Other: ______

Group Voluntary Buy-up: ☐

Dependent Life: ☐

AD&D Rider: ☐

Special Requests: ______________________

____

____

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____

Group STD/LTD Quotes Req.

Desired Effective Date of Coverage: ☐

Insurance Carrier	**Request**
All Carriers	☐
-MetLife	☐
-AlwaysCare	☐
-Reliance Standard	☐
-Lincoln Financial	☐

Plan Specifications

Quote same as current *(Must include current benefits summary)*	☐
100% Employer-Paid	☐
100% Voluntary	☐
Employer pays ≥ 50% of EE cost	☐

Alt. STD Plan Designs Requested

Benefit: (*Accident / Illness / Duration)*

1/8/13 ☐ **1/8/26** ☐ **8/8/13** ☐ **8/8/26** ☐

Maximum *Weekly* Benefit :

$200 ☐ **$300** ☐ **$400** ☐ **$500** ☐ **Other:** ☐

Alt. LTD Plan Designs Requested

Elimination Period: *(Weeks)*

13 ☐ **26** ☐ **Other:** ☐

Percentage of Pay

50% ☐ **60%** ☐ **66.67%** ☐ **Other:** ☐

Maximum *Monthly* Benefit:

$1500 ☐ **$2000** ☐ **$3000** ☐ **$4000** ☐ **Other:** ☐

Coverage Definitions

Own Occupation: ☐

Any Occupation: ☐

IV Requested Items

A. Census (including ALL eligible. Includes wages for D.I. quotes)	☐	**Attached**
B. Copies of Recent Billing Statements for all quoted lines:	☐	**Attached**
C. Copies of Benefits Schedules or Employee Benefits Booklets:	☐	**Attached**

NOTES:______________________

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Email completed RFP to Jamie Shawa at jshawa@michamber.com