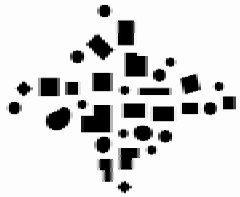


Fortis Insurance Company

Proposal Request

Part 1



FORTIS

Solid partners, flexible solutions[®]

**Fax this completed form to:
Beneflex Financial Group
FAX: 713-455-3068**

IMPORTANT

Requesting a Fortis Insurance Company small group quote requires 3 parts.

1. Completion of **Part 1** (Group and Plan Data).
2. Completion of **Part 2** (Employee Data) or submission of a similar form with the necessary employee information.
3. Completion of **Part 3** (Medical Data).

All information must be provided and **all 3 parts must be submitted** in order to receive a new business quote.

Incomplete forms will be returned. Make copies of this form for subsequent requests.

Home Office Use Only:	Factor	UW'R
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Agent Information	
Agent: _____	Fortis Agent Number: _____
Agency Name: _____	
Fax Number: _____	Telephone Number: _____

Group Information	
Name: _____	
City: _____	State: _____ 5-Digit ZIP Code: _____
Number of Employees: Full-time: _____ Part-time: _____	On COBRA: _____
Effective Date: <input type="checkbox"/> 1 st <input type="checkbox"/> 15 th	JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Type of Business: _____	SIC Code: _____
Does employer currently have group medical coverage?	Yes No
If yes, list group medical carrier: _____	
Does employer currently have Workers' Compensation?	Yes No

For agent use only.
Insurance contracts are underwritten and issued by Fortis Insurance Company,
Fortis Health member company. Fortis Health is located in Milwaukee, WI.

Proposal Request

Part 1 cont'd.



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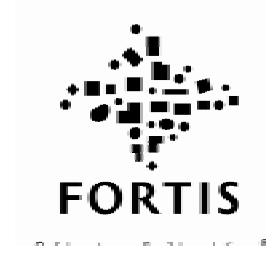
Solid partners, flexible solutions.®

Medical Plan Specifications <small>(Circle your choices and complete blanks where appropriate.)</small>								
PPO network selection: _____								
Lifetime Maximum Benefit:		\$2 million		\$5 million		\$8 million		
Annual Deductible:	\$0	\$250	\$500	\$1,000	\$1,600	\$1,750*	\$2,000**	
† available with HRA	\$2,250*	\$2,500†*	\$2,400	\$3,000†	\$5,000†	\$10,000†		
*available with MSA	For an HRA, indicate Family Deductible Accumulation:						Individual	Common Family
Rate of Payment:	50%	60%	70%	80%	90%	100%		
Annual Out-of-Pocket Limit:	\$1,250	\$2,000	\$1,500	\$1,000	\$1,000	\$1,000		
	\$2,500	\$4,000	\$3,000	\$2,000	\$2,000	\$1,000		
	\$5,000		\$4,500	\$3,000	\$3,000	\$1,500		
			\$6,000	\$4,000	\$4,000	\$2,000		
HRA Plan Design <small>(HRA plans only):</small>	EE pays first		ER pays first		Split deductible		Sandwich deductible	
MSA Funding Responsibility <small>(MSA plans only):</small>	EE funded			ER funded				
Office Visit Copay:	\$20/\$20		\$20/\$30		\$20/\$40			
	\$25/\$25		\$25/\$40		\$30/\$30		\$30/\$50	
Maternity <small>(Optional for groups of 3-9):</small>	YES			NO				
Optional \$500 X-ray & Lab Benefit:	YES			NO				
Hospital Copay <small>(Healthy Edge only):</small>	\$500		\$1,000		\$2,000			
Optional Rx Drug Program:	YES		NO		<small>(If Yes, complete Rx Deductible and Rx Copay.)</small>			
Rx Deductible:	\$0	\$100	\$250	\$500	Copay:	\$15/45	\$15/\$30 + 20%	
Optional Accident Medical Expense:	YES		NO		<small>(If Yes, select amount.)</small>			
	\$300	\$500	\$1,000	\$2,000	\$5,000*			
<small>* only available with \$5,000 or \$10,000 deductibles</small>								
Non-Medical Coverages <small>(Circle your choices and complete blanks where appropriate.)</small>								
Term Life:	Level 1		Level 2		Level 3			
	<small>Minimum \$10,000, Maximum \$250,000 (\$1,000 increments) Maximum additional amounts up to 2 1/2 times prior amount</small>							
Disability (Optional):	YES <small>(provide employee salaries)</small>					NO		
Duration:	26 weeks			52 weeks				
	Level 1		Level 2		Level 3			
	<small>Minimum \$100, Maximum \$1,000 (\$10 increments)</small>							
<small>See brochure for plan details.</small>	Circle Plan and Benefit Year Maximum where indicated							
Dental (Optional):	PPO Plan 1	PPO Plan 2	Access Plan 1	Access Plan 2	Access Plan 3	Access Plan 3	Access Plan 3	
			(or Indemnity)	(or Indemnity)	(or Indemnity)	(or Indemnity)	(or Indemnity)	
Benefit Year Maximum:	\$1,000/ \$750	\$1,000/ \$750	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	
	\$2,000/\$1,000	\$2,000/\$1,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	
	\$2,000/\$1,500	\$2,000/\$1,500	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	
Orthodontic Coverage <small>(Groups of 10 or more):</small>	None		Full Family		Child Only			
Previous Dental	YES		NO					
Waive Waiting Period for Major Services <small>(Groups of 15 or more)</small>	YES			NO				
Dependent Participation for Dental	_____ %							

EE = Employee ER = Employer

Fortis Insurance Company

Proposal Request for Employee Choice and Remote Employees *Part 4*



For use with groups that:

1. offer the Employee Choice program or
2. have "remote" employees who either live outside the state or primary PPO area or
3. have employees who work at a second location which is outside the state or PPO area.

Section 1

Complete this section if the employer has selected the Employee Choice program. For each additional plan, indicate the deductible, rate of payment, out-of-pocket limit and network. Then list the line numbers from the Employee Data section of the Proposal Request form for each employee to be enrolled in this plan.

	Plan 2	Plan 3	Plan 4
Deductible:	_____	_____	_____
Rate of Payment:	_____	_____	_____
Out-of-Pocket Limit:	_____	_____	_____
Network:	_____	_____	_____
Employee Line Numbers: <i>(from Page 3)</i>	_____	_____	_____

Section 2

Complete this section if the employer has "remote" employees who live outside the state or the primary PPO area. Identify each "remote" employee by the appropriate line number from the Employee Data section of the Proposal Request form. Provide the ZIP code and, if appropriate, the different network choice for each out-of-state employee

Employee Line Number	ZIP Code	Network	Employee Line Number	ZIP Code	Network
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Section 3

Complete this section if there is a second work location outside the state or the primary PPO are. Complete the information for the secondary location and list the appropriate line numbers from the Employee Data section of the Proposal Request form for each employee working at the second location.

City	State	ZIP Code
_____	_____	_____

Employee Line Numbers: _____