PROPOSAL REQUEST

Group Name _____
Address_____
_____
City _____ St_____ Zip _____
County_____ Nature of Business _____
S I C code _____

Agent Name Jerry Hill_____
Agency Beneflex Financial Group_____
Address P.O. Box 1125_____
City Crosby St. Tx Zip 77532
Phone / 713.455.7087 800.926.9107_____
Fax / 713.455.3068 800.884.2798_____
Email/ Jerry@beneflexfinancial.com_____

Does the group have current coverage and with who?
_____

Medical Questions:
_____ Any employees or dependent pregnant?
_____ Anyone been confined to a hospital in past 12 months?
_____ Anyone currently disabled?
_____ Anyone incurred $2,500 or more in medical expenses in last 12 months?
_____ Anyone on Cobra?
_____ Anyone received treatment for cancer, heart, stroke, diabetes, kidney disorder, immune system disorder, psychological, alcohol or drug disorder?
If yes, please provide the following information:
Employee/ dependent: _____

Diagnosis: _____ Date of Diagnosis_____
Dates of treatment: _____
Medications: _____
Is condition on-going? _____
Date of onset _____
Please indicate which plans you would like to appear on proposal:
Office Co Pay: __ $10 __$15 __$20 __$25 __ $30 __$40
70/30 Deductible: ____ $100 ___$250 ___$500 ____ $1,000 _____$1,500 ____$2,000
80/20 Deductible: ____ $100 ___$250 ___$500 ____ $1,000 _____$1,500 ____$2,000
60/40 Deductible: ____ $100 ___$250 ___$500 ____ $1,000 _____$1,500 ____$2,000
90/10 Deductible: ____ $100 ___$250 ___$500 ____ $1,000 _____$1,500 ____$2,000
50/50 Deductible: ____ $100 ___$250 ___$500 ____$1,000 _____$1,500 ____$2,000
Stop Loss _____$2,500 _____$5,000 _____$10,000
PPO Network you prefer:_____
125 Flex Funding: ____Yes ____No

(Please list additional conditions/ information on separate sheet)

LIFE and AD&D	OPTIONS
Face amount needed $_____	_____ Dental 24 Hr Coverage _____ 24 hour coverage Yes or No Drug Card Yes or No Short term disability

Med Coverage Code

E E -Employee **E C-Employee & Child (ren)**

E S -Employee & Spouse **E S C- Employee, Spouse & Child (ren)**

Sex	Med Cov	Employee only Birtdate	Job description and weekly income (for disability coverage only)
M F	EE EC ES ESC		
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