17819 Commerce Drive, Suite 200
Westfield, IN 46074
(253) 984-0766 / (800) 275-5028

Request for Proposal (RFP)

Dental, Medical,Vision, Life, STD, LTD, Medical Gap, Work-site

Thank you for selecting Agent Brokerage Alternatives to assist you in choosing benefits that best fit your client's needs. Please complete first page and all sections on page 2 applicable to the coverages for which you are requesting a proposal. Please attach a census (excel format to include- gender, date of birth, occupation and salary), current plan design, experience information and rates.

Date:		Due Date:		Requested Effective Date:	

Group Name:			SIC Code/ Type of Business:	
Group Address:				
City:		State:		Zip:	
Years in Business:		Tax ID Number:		
# of Eligible Employees:		Eligible employees must work # of hrs/wk:		
Wait period for new hires:		Are there existing benefits?	☐ Y ☐ N	

Agency Name:			
Agent Name:			
Email:		Are you the Broker of Record?	☐ Y ☐ N
Phone:		Fax:	

Please check all products to be proposed and fill out page 2:

☐ **Dental** ☐ **Medical**** ☐ **Vision** ☐ **Medical Gap***

☐ **Life AD&D*** **STD*** **LTD*** **Work-Site, CI, AI, Hosp.***

***Complete excel census required for all Life/STD/LTD Products, **Please provide copy of Summary Benefit Description**

Additional Comments:	

Please submit RFP to quotes@abalternatives.com or Fax (317) 776-3704
For Questions regarding this RFP please contact Agent Brokeage at (253) 984-0766 or (800) 275-5028

Please provide a current summary of benefits for all existing plans you wish to match benefits.

Dental			**Match Benefits:** ☐ **Yes** ☐ **No**		
Employer Contribution:	☐ Voluntary		☐ Contributory/ Employer Paid		
Tier Rate	☐ 2-Tier		☐ 3-Tier		☐ 4-Tier
Annual Maximum:	☐ $1000	☐ $1200	☐ $1500 (5+ee's)	☐ $2000(10+ee's)	☐Other________
Indemnity Ortho Benefit:	☐ $1000	☐ $1500	☐ $2000	☐ Other	
Endo and Perio Services:	☐ Basic ☐ Major	Deductible:	☐$50/$150 ☐$25/$75 ☐ Other:__________	Previous Carrier Name:	
Current Rates	E Only $__________	E+Spouse $_________	E+Child(ren) $__________	E+Family $__________	
Renewal Rates	E Only $__________	E+Spouse $_________	E+Child(ren) $__________	E+Family $__________	

Vision			**Match Benefits:** ☐ **Yes** ☐ **No**	
Employer Contribution:	☐ Voluntary	☐ Contributory/ Employer Paid		
Frequency of Exam, Lenses, Frames (in mos.):	☐ 12/24/24	☐ 12/12/24		☐ 12/12/12
Material Allowance (Frames or contacts):	☐ $100	☐ $130	☐ $150	☐ Other___________
Copays (Exam/Material):	☐ $10/$15	☐ $15/$15	☐ $10/$25	☐ Other______________
Plan Type	☐ Full Service	☐ Materials-Only	Previous Carrier Name:	
Current Rates	E Only $___________	E+Spouse $____________		E+Family $_____________
Renewal Rates	E Only $___________	E+Spouse $____________		E+Family $_____________

Life AD&D **Voluntary** ☐ **Yes** ☐ **No**	☐ **STD** **Voluntary** ☐ **Yes** ☐ **No**	☐ **LTD** **Voluntary** ☐ **Yes** ☐ **No**
☐ Flat Amount $_____________on all full time employees	☐ Flat Amount $_____________ / wk on all full time employees	☐ Percent of Earnings _____ % of earnings to $___________ max monthly benefit of full-time employees (standard)
☐ Multiple of Earnings _____ X Earnings on all employees to max of $_____________	☐ Percent of Earnings _____ % of earnings to the max benefit of $_____________	
☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________	☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________	☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________
Employer Contribution ________%	Employer Contribution ________%	Employer Contribution ________%
Current Rate ________ per $1000	Current Rate ________ per $10	Current Rate ________ per $100
Renewal Rate ________ per $1000	Renewal Rate ________ per $10	Renewal Rate ________ per $100
LIFE REDUCTIONS	SHORT TERM DISABILITY	Elimination Period: ☐ 90days ☐ 120 days ☐ 180 days ☐ Other________
☐ 35% at 65, Terminate at 70 or retirement (Groups 2-9)	_________ day(s) accident _________ days sickness _________ weeks	Benefit Integration: ☐ Primary & Family (standard) ☐ Primary Only
☐ 35% at 65, 50% at 70, 75% at 75, Terminate at Retirement (Groups 10+)		Benefit Duration: ☐ To Age 65 RBD ☐ 5 Year ☐ 2 Year
☐ Other_____________________________	1/8/13 or 1/8/26 (standard)	Own OCC Definition: ☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ To Age 65
Extended Death Benefit (Groups2-9) **Waiver of Premium (Groups 10+)**		
☐ Dependent Life Amount Spouse $__________ Child(ren) $__________		
☐ Life Claims Experience Attached (Groups 150+)	☐ STD Claims Experience Attached (Groups 100+)	☐ LTD Claims Experience Attached (Groups 200+)

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☐ **Medical Gap** **Voluntary ☐ Yes ☐ No**	**Worksite Plans**
☐ Employer contribution %__________ or $______________on all full-time employees	☐ Critical Illness ☐Hospital Indemnity ☐ Accident Expense
In-Hospital Benefit: Plan I: $_________________ ☐ $______ Plan II: $_________________ ☐$______	Employer Contribution ________% Critical Illness Lump Sum Amount: $10,000 $20,000 $30,000
Outpatient Benefit: ☐ OP I: ☐ OP II: ☐ Plan I: $ _____ ☐ Plan II: $______ Physician Benefit: ☐ Plan I: $_______ ☐ Plan II: $_________ ☐ $15 visit, $120 or 8 visits/family/year ☐ $20 visit, $240 or 12 visits/family/year	Hospital Indeminty Lump Sum: $1,000 $1,500 Accident Expense: Include 24 hour coverage Include AD&D

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