

REQUEST FOR PROPOSAL

LONG TERM DISABILITY

Group Name: _____ Agent: _____

GROUP HISTORY: Past Experience Required/Premium and Paid Claim for Last 3 Years 200+ Lives; 5 Years 500+ Lives

Date: ____/____/____ Date Needed: ____/____/____

Present Carrier: _____ Effective Date: ____/____/____

Current Carrier Rates: \$ _____ Employer Contribution (specify \$ or %): _____

Are there any Open Claims: Yes* No

**(If yes, provide age, nature of disability, incurred date of disability, and benefit amount for each on the reverse side.)*

SCHEDULE OF PROPOSED BENEFITS:

Number Eligible	Employee Classification (Job Title, Salary, Etc.)	Maximum \$ Benefit
A. _____	_____	\$ _____
B. _____	_____	\$ _____
C. _____	_____	\$ _____
D. _____	_____	\$ _____

Minimum Benefit: \$50/10% \$100/10% Other \$ _____

Benefit Percent: 50% 60% 66 2/3% Other _____%

Benefit Duration: RBD 2 Years 5 Years 65/5/70 70 Other _____

Elimination Period: 30 Days 60 Days 90 Days 180 Days Other _____

Pre-Existing Limit: 12/6/24 (<25 grps) 3/6/12 (25+ grps) 5 Days Other _____

Integration: Primary Primary & Family Other (describe on reverse side)

Mental/Nervous Limitations: 24 Months Other _____

Survivor Benefit: 3 Months 12 Months Other _____

Definition of Disability: 24 Months Own Occupation 36 Months Own Occupation

Other _____