

**REQUEST FOR PROPOSAL**

**LIFE-AD&D SHORT TERM DISABILITY**

Agent: \_\_\_\_\_ Group Representative: \_\_\_\_\_

**I. GENERAL INFORMATION**

Date: \_\_\_\_\_ Date Needed: \_\_\_\_\_  
 Name of Group: \_\_\_\_\_ Proposed Effective Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Waiting Period  
 City, State, Zip: \_\_\_\_\_ for Employees \_\_\_\_\_  
 Nature of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_  
 Employer Contribution: \_\_\_\_\_ % For Dependents: \_\_\_\_\_ %  
 Number of Employees: \_\_\_\_\_

**\*\*\*Current Census data indicating date of birth, sex, class and dependent status must be attached.\*\*\***

**II. PROPOSED SCHEDULE OF BENEFITS**

Employee Classification (Job Title, Salary, Etc.)	Maximum Benefit			
	Life	AD&D	STD	Supplemental
A. _____	_____	_____	_____	_____
B. _____	_____	_____	_____	_____
C. _____	_____	_____	_____	_____
D. _____	_____	_____	_____	_____

Please describe any classification of full-time employees that are to be excluded from coverage: \_\_\_\_\_

**Life & AD&D Benefits:** (will terminate at retirement unless otherwise stated)

- Reduce \_\_\_\_\_ % at Age \_\_\_\_\_ and \_\_\_\_\_ % at Age \_\_\_\_\_  
 Terminate at Age \_\_\_\_\_

**Dependent Life Benefits** (check plan desired)

	Spouse	*Child(ren) 6 mos. to age 21 (or 23 if a FT student)
_____ Plan I	\$2,000	\$1,000
_____ Plan II	\$2,500	\$1,500
_____ Plan III	\$5,000	\$2,500
_____ Plan IV	\$1,000	\$1,000
_____ Plan V	\$2,000	\$2,000
_____ Other		

**STD Benefits Payable**

- A. \_\_\_\_ Day Accident \_\_\_\_ Day Sickness \_\_\_\_ Duration  
 B. \_\_\_\_ Day Accident \_\_\_\_ Day Sickness \_\_\_\_ Duration  
 C. \_\_\_\_ Day Accident \_\_\_\_ Day Sickness \_\_\_\_ Duration  
 D. \_\_\_\_ Day Accident \_\_\_\_ Day Sickness \_\_\_\_ Duration  
 1st Day Hospital \_\_\_\_ Yes \_\_\_\_ No

\*Child(ren) benefit will be \$100 for child(ren) 15 days but less than 6 months.

**Comments:**

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**Long Term Disability**

If Long Term Disability proposal is needed, please complete the LTD Request for Proposal.

The Census must include occupations and salaries.

**III. INSURANCE CARRIER HISTORY**

**A. Must be completed for All Groups**

Name of Current Carrier: \_\_\_\_\_

Effective Date with this Carrier\*: \_\_\_\_\_

\*If this Date is Less than Two Years Ago, Please Provide:

Name of Prior Carrier: \_\_\_\_\_

Effective Date with Prior Carrier: \_\_\_\_\_

Current Carrier Rates: Life \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_ STD \$ \_\_\_\_\_

Dependent Life: \$ \_\_\_\_\_

These Rates were Effective: \_\_\_\_\_

A Copy of the Current Schedule of Benefits Must be Included.

**B. Must be Completed for Groups of More than 200 Lives for STD (500+ Lives - Life/AD & D).**

1. History of In-Force Rates for the Last 3 Years.
2. Premium and Paid Claim Information by Line of Coverage for the Last 3 Years on Current Carrier Forms.
3. History of Benefit Changes for the Last 3 Years.