

# California DENTAL

A DENTAL HEALTH PLAN

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## REQUEST FOR PROPOSAL

1. Name of Prospect \_\_\_\_\_

2. Location(s) \_\_\_\_\_ Zip Code(s) \_\_\_\_\_

3. Nature of Business \_\_\_\_\_ SIC Code \_\_\_\_\_

4. Are You Currently the Agent/Broker? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Does Prospect Currently Have Dental Coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes:

A. What is/are the Current Plan(s)? (Please Include Benefit Summaries)

Prepaid \_\_\_\_\_ PPO/Indemnity \_\_\_\_\_

B. Prepaid Rates:

Current Employee \_\_\_\_\_ EE + Spouse \_\_\_\_\_ EE + Child(ren) \_\_\_\_\_ Family \_\_\_\_\_

Renewal Employee \_\_\_\_\_ EE + Spouse \_\_\_\_\_ EE + Child(ren) \_\_\_\_\_ Family \_\_\_\_\_

C. PPO Rates:

Current Employee \_\_\_\_\_ EE + Spouse \_\_\_\_\_ EE + Child(ren) \_\_\_\_\_ Family \_\_\_\_\_

Renewal Employee \_\_\_\_\_ EE + Spouse \_\_\_\_\_ EE + Child(ren) \_\_\_\_\_ Family \_\_\_\_\_

6. Total # of EE's \_\_\_\_\_ # of Eligible EE's \_\_\_\_\_ # of Participating EE's \_\_\_\_\_.

Prepaid # EE \_\_\_\_\_ #EE +Spouse \_\_\_\_\_ # EE+ Child(ren) \_\_\_\_\_ # Families \_\_\_\_\_

PPO # EE \_\_\_\_\_ #EE +Spouse \_\_\_\_\_ # EE+ Child(ren) \_\_\_\_\_ # Families \_\_\_\_\_

7. What Percentage of the Employee Premiums is the Employer Contributing? \_\_\_\_\_%

8. What Percentage of the Dependent Premiums is the Employer Contributing? \_\_\_\_\_%

9. Requested Coverage:

Prepaid Plan # and/or Benefits \_\_\_\_\_

PPO/Indemnity Benefit Max., Deduct. (With Ortho? For Adults?) \_\_\_\_\_

10. Requested Effective Date \_\_\_\_\_ 11. Date Needed By (Deadline) \_\_\_\_\_

12. Your Agent Name \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

E-mail Address (If you'd like the quote emailed) \_\_\_\_\_