



# Request for Proposal

<b>Name of Prospect:</b>	<b>Proposed Effective Date:</b>	<input type="checkbox"/> Limited Medical	<input type="checkbox"/> Dental
		<input type="checkbox"/> GAP	<input type="checkbox"/> Vision
<b>Prospect's Address:</b>	<b>Number Eligible Employees:</b>	<input type="checkbox"/> Major Medical	<input type="checkbox"/> RX
		<input type="checkbox"/> Section 125	<input type="checkbox"/> Admin. Services Only
<b>Industry (please be specific):</b>			
<b>List Other Locations Including Zip Codes:</b>			
<b>CENSUS REQUIRED FOR GAP &amp; MAJOR MEDICAL QUOTES - Please attach a census including age (or date of birth), Gender, Zip Code and current Medical tier.</b>			
<b>Name of Agent/Broker/Consultant:</b>		<b>Phone:</b>	
		<b>Fax:</b>	
		<b>Email:</b>	
<b>Name of Group Representative:</b>			
<b>Included a copy of the current plan design:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please list current and renewal rates:</b>			
<b>What employer contributions are anticipated per employee per month? (please circle one)</b>			
0%	25 %	50%	100 %      Not sure yet
<b>Please describe any other medical benefits the employer makes available to this group of employees or that the employer may be interested in:</b>			
<b>Additional Information:</b>			

**Submit Proposal requests to:**  
**OptiMed's Proposal Department**  
**Proposal@optimedhealth.com**  
**Or Fax to: 215-968-6301**