



**Business Health Trust
PROPOSAL REQUEST FORM**

Wells Fargo Insurance Services

| | | | | |
|---|--|---|---|--------------------|
| Group Legal Name: | | Company Website: Description of Business: | | SIC Code: |
| Group Address: | | City, State: | Zip: | Years in Business: |
| Requested Effective Date: ____/____/____ | Current Renewal Date: Medical: ____/____/____ Dental: ____/____/____ | Is group currently an active dues member of a BHT Endorsed Sponsor? <input type="checkbox"/> Yes, please indicate _____ <input type="checkbox"/> No | | |
| Employer Premium Contribution: (Minimum 75%/0%) | | Employee: _____% Dependents: _____% | | |
| Current Benefits - Medical | | | | |
| Medical Carrier: | | How long with this carrier? | | |
| Medical plan design (PPO, POS, HMO): | | Co-insurance: | Prev. Care: | |
| Deductible: Individual: _____ Family: _____ | | Out-of-pocket max: Individual: _____ Family: _____ | | |
| Office visit copay: | Prescriptions: | Riders: | | |
| Current Benefits - Dental | | | | |
| Dental Carrier: | | How long with this carrier? | | |
| Deductible: Individual _____ Family _____ Waived for P/D? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Annual Maximum: | Orthodontia included? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Coinsurance: Preventive & Diagnostic: ____% | | Basic Services: ____% | Major Services: ____% | |
| Current Benefits - Vision | | | | |
| Vision Carrier: | | Frequency of coverage (Exam/Lens/Frames): <input type="checkbox"/> 12/12/12 <input type="checkbox"/> 12/12/24 <input type="checkbox"/> 24/24/24 | | |
| Current Rates | | | | |
| | Medical | Medical | Dental | Vision |
| Employee | | | | |
| EE/Spouse | | | | |
| EE/Child(ren) | | | | |
| EE/Family | | | | |
| Renewal Rates | | | | |
| | Medical | Medical | Dental | Vision |
| Employee | | | | |
| EE/Spouse | | | | |
| EE/Child(ren) | | | | |
| EE/Family | | | | |
| Submitting BHT Broker/Agent: | | Return this form, employee census & HRQ to: Email: bht.ins@wellsfargo.com Forms can be found at: www.businesshealthtrust.com Broker line: 206.892.9562 Fax: 866.972.2881 | | |
| Brokerage/Agency Name: | | | | |
| Return quote to: | | | | |
| Email: | | | | |