Fax this request along with proof of eligibility to toll-free (866) 271-5344

Request an Assurant Insurance Company small group quote.

1. Completion of ***Part 1*** (Group and Plan Data).
2. Completion of ***Part 2*** (Employee Data) or submission of a similar form with the necessary employee information.
3. Completion of ***Part 3*** (Medical Data). **Not required for quote, but please do realize that final rates are based on medical underwriting.**

Agent Information

Agent: Tony Novak Fortis Agent Number: 275951

Agency Name: Freedom Benefits

Fax Number: 866-271-5344 Telephone Number: 610-664-8669

Group Information

Name: _____

City: _____ State: _____ 5-Digit ZIP Code: _____

Number of Employees: Full-time: _____ Part-time: _____ On COBRA: _____

Effective Date: 1st 15th JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Type of Business: _____

Does employer currently have group medical coverage? Yes No

If yes, list group medical carrier: _____

Does employer currently have Workers' Compensation? Yes No

Medical Plan Specifications *(Circle your choices and complete blanks where appropriate.)*

PPO network selection: _____

Lifetime Maximum Benefit:			$2 million			$5 million	$8 million
Annual Deductible:	$0	$250	$500	$1,000	$1,600	$1,750*	$2,000
	$2,250*	$2,400	$3,000	$5,000	$10,000	**MSA only*	
For an HRA, indicate Family Deductible Accumulation:			Individual	Common Family			

Rate of Payment:	50%	60%	70%	80%	90%	100%
Annual Out-of-Pocket Limit:	$1,250 $2,500 $5,000	$2,000 $4,000	$1,500 $3,000 $4,500 $6,000	$1,000 $2,000 $3,000 $4,000	$1,000 $1,000 $1,500 $2,000	(All HRA's & MSA's are 100% after the ded.)

HRA Plan Design *(HRA plans only)*:	EE pays first	ER pays first	Split deductible		
MSA Funding Responsibility *(MSA plans only)*:	EE funded	ER funded			
Office Visit Copay:	$15/$15	$15/$30	$20/$20	$20/$30	$20/$40
Not with HRA's & MSA's	$25/$25	$25/$40	$30/$30	$30/$50	
Maternity *(Optional for groups of 3-9):*	YES	NO			
Optional $500 X-ray & Lab Benefit:	YES	NO			
Hospital Copay *(Healthy Edge only):*	$500	$1,000	$2,000		
Optional Rx Drug Program: **Not with HRA's & MSA's**	YES	NO	*(If Yes, complete Rx Deductible and Rx Copay.)*		
Rx Deductible:	$0	$100	$250	$500	
Rx Copay:	$15/45	$15/$30 + 20%			

Non-Medical Coverages *(Circle your choices and complete blanks where appropriate.)*

Term Life: Level 1 Level 2 Level 3

Minimum $10,000, Maximum $250,000 ($1,000 increments) Maximum additional amounts up to 2 1/2 times prior amount

Disability (Optional): YES *(provide employee salaries)* NO

Duration: 26 weeks 52 weeks

Level 1 Level 2 Level 3

Minimum $100, Maximum $1,000 ($10 increments)

See brochure for plan details. ***Circle Plan and Benefit Year Maximum where indicated***

Dental *(Optional)*:	**PPO Plan 1**	**PPO Plan 2**	**Access Plan 1 (or Indemnity)**	**Access Plan 2 (or Indemnity)**	**Access Plan 3 (or Indemnity)**
Benefit Year Maximum:	$1,000/ $750	$1,000/ $750	$1,000		
	$2,000/$1,000	$2,000/$1,000	or $2,000		
	$2,000/$1,500	$2,000/$1,500			

Orthodontic Coverage *(Groups of 10 or more)*:	None	Full Family	Child Only
Previous Dental	YES	NO	
Waive Waiting Period for Major Services *(Groups of 15 or more)*	YES	NO	

Dependent Participation for Dental _____ %

EE = Employee ER = Employer

Assurant Insurance Company

Proposal Request

Part 2

Group Name: _____

Instructions For each employee, circle the appropriate response for **Gender, Medical Coverage, Dental Coverage** (if applicable), and **Life or DI Benefit Level** (if more than one level has been requested). Also, provide **Date of Birth or Age**, **Child Count** for medical (if applicable) and indicate if any employee is on **COBRA**. *See example below.*

For Groups with more than 25 employees, make copies of this page.

Key for Coverage Codes
E = Employee Only S = Employee + Spouse C = Employee + Child(ren) F = Full Family N = No Coverage

	AGE or DOB	GENDER		MEDICAL COVERAGE					CHILD COUNT	DENTAL COVERAGE					LIFE or DI LEVEL			ON COBRA?
1	**47**	(M)	F	(E)	S	C	F	N		E	S	(C)	F	(N)	1	2	3	**N**
2	**32**	(M)	F	E	(S)	C	F	N		(E)	S	C	F	N	1	2	3	**Y**
3	**MM/DD/YY**	M	(F)	E	S	(C)	F	N	**3**	E	S	(C)	F	N	1	(2)	3	**N**

	AGE or DOB	GENDER		MEDICAL COVERAGE					CHILD COUNT	DENTAL COVERAGE					LIFE or DI LEVEL			ON COBRA?
1		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
2		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
3		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
4		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
5		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
6		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
7		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
8		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
9		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
10		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
11		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
12		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
13		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
14		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
15		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
16		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
17		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
18		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
19		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
20		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
21		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
22		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
23		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
24		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	
25		M	F	E	S	C	F	N		E	S	C	F	N	1	2	3	

Assurant Insurance Company

Proposal Request
Part 3

Group Name: _____ Date: _____

Number of Medical Certs: Employee Only Employee + Spouse
Employee + Child(ren) Full Family

Answer the following questions for employees and their dependents. Is / has any employee or dependent:

NO	YES	
☐	☐	Incurred medical claims of more than $5,000 during the past 12 months? If yes, give reasons: _____ _____ _____
☐	☐	Within the past 6 months been disabled or hospital confined? If yes, give reasons: _____ _____ _____
☐	☐	Currently pregnant? If yes, give due date: _____
☐	☐	Been diagnosed as having or received treatment in the past five years for:

a. Cancer or malignancy
b. Heart disorder, heart disease or stroke
c. Acquired immune deficiency syndrome (AIDS) or AIDS Related Complex (ARC)
d. Received treatment for drug abuse or chemical dependency
e. Received treatment for alcohol abuse
f. Diabetes (insulin dependent)

Proposed rates are not binding and final approval will only be given following receipt and approval of a properly completed application. Any changes in group composition or medical history may require additional evaluation. Fortis Health complies with all state and federal mandated requirements regarding the acceptance and issuance of Small Group medical coverage.

Rates are based on medical history disclosed on this form. If circumstances change, a new quote must be requested.

I hereby certify that to the best of my knowledge, the information provided herein is complete and true.

AGENT SIGNATURE _____ **DATE** _____

Assurant Insurance Company

Proposal Request for Employee Choice and Remote Employees *Part 4*

For use with groups that:

1. offer the Employee Choice program or
2. have "remote" employees who either live outside the state or primary PPO area or
3. have employees who work at a second location which is outside the state or PPO area.

Section 1

Complete this section if the employer has selected the Employee Choice program. For each additional plan, indicate the deductible, rate of payment, out-of-pocket limit and network. Then list the line numbers from the Employee Data section of the Proposal Request form for each employee to be enrolled in this plan.

	Plan 2	Plan 3	Plan 4
Deductible:	_____	_____	_____
Rate of Payment:	_____	_____	_____
Out-of-Pocket Limit:	_____	_____	_____
Network:	_____	_____	_____
Employee Line Numbers: *(from Page 3)*	_____	_____	_____

Section 2

Complete this section if the employer has "remote" employees who live outside the state or the primary PPO area. Identify each "remote" employee by the appropriate line number from the Employee Data section of the Proposal Request form. Provide the ZIP code and, if appropriate, the different network choice for each out-of-state employee

Employee Line Number	ZIP Code	Network	Employee Line Number	ZIP Code	Network
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Section 3

Complete this section if there is a second work location outside the state or the primary PPO are. Complete the information for the secondary location and list the appropriate line numbers from the Employee Data section of the Proposal Request form for each employee working at the second location.

City	State	ZIP Code
_____	_____	_____

Employee Line Numbers: _____