



Group Census Request For Proposal

Company Information

Company Name:		Effective Date:		Current Carrier:	
Address:		Contact name:		EE Rate:	
Email:		Phone:		# of Employees:	
Type of Business:		Fax:		Plan Type:	
<i>Please attach current bill and summary if available.</i>					

** Elected Coverage: Employee Only=EE Employee + Spouse=ES Employee + Child=EC Employee + Children=ECH Employee + Family=F

Name	DOB /Age	Gender	Home ZIP	Medical Coverage	Spouse DOB / Age	Number of Children	Dental Coverage (if applicable)	Vision Coverage (if applicable)	Status- (Active, COBRA, Term, Waived)	For Disability Quote Only	
										Job Title	Annual Salary
Example- Name/ EE1	10/2/1968	M	89502	ES	11/6/1970	0	ECH-2	ES	Active	i.e Class 1 Mgt	\$35,000

I am interested in receiving quotes for the following benefits: Medical: PPO HMO POS HRA HSA Dental Vision Life Buy-Sell 401K IRAs LTD STD Voluntary Benefits Human Resource Services Payroll

Other: _____

(775) 828-7420 • fax (775) 828-7426 • 560 Hammill Lane • Reno, NV 89511 • www.clarkandassoc.com • Or Email info@clarkandassoc.com

Broker / Consultant

BSC Name:	
BSC Email:	