

PROPOSAL REQUEST FORM

Company Name	Contact Person	Phone
---------------------	-----------------------	--------------

Address	City	State	Zip
----------------	-------------	--------------	------------

Agent	Contact Person	Union/Local	Phone
--------------	-----------------------	--------------------	--------------

1. **Number of Employees**

_____ Professional	_____ Professional
_____ Skilled	_____ Skilled
_____ Clerical	_____ Clerical
_____ Semi-Skilled	_____ Semi-Skilled
_____ Unskilled	_____ Unskilled

2. **If coverage will include retirees, total number:** _____

3. **Employee turnover per year:**

_____ 0% to 10%	_____ 10% to 17%	_____ 18% to 25%	
_____ 26% to 33%	_____ 34% to 40%	_____ over 40%	

4. **Prior dental coverage:**

_____ None _____ 1 year _____ 2 years _____ 3 or more
years

5. **Current dental plan (s) - attached benefit schedule (s))**
Carrier _____

Type I ___ **Type II** ___ **Type III** ___ **Type IV** ___ **Ded** ___ **Annual** ___ **Ltm** ___

6. **Monthly rates and number of employees enrolled in present dental coverage:**

	# Employees	Monthly Rate
Employee only	_____	_____
Employee plus spouse	_____	_____
Employee plus one child	_____	_____
Employee plus two or more dependents	_____	_____

7. **Renewal period of current programs** _____ **Open enrollment** _____

8. **Preferred effective date:** _____ **Employee Contribution** _____

Comments: _____

Account Representative

Date