



Request for Proposal (RFP)

Please fill out the following form. Once completed please send us a copy in one of the following ways:

Email | agentsupport@directbenefits.com Fax | 651-649-3502

Date _____ Date Needed _____

Group Name _____

City _____ State _____ Zip Code _____

Nature of Business or SIC Code _____ Requested Effective Date _____

of Eligible Employees* _____ Are Employees 100% Family Related? Yes No

Producer's Name _____

Phone Number _____ Email _____

Current Coverage Information | **Include a copy of current plan design and renewal rates, if available

of Employees Enrolled _____

Current Rates: EE _____ EE + Spouse _____ EE + Child(ren) _____ Family _____

Renewal Rates: EE _____ EE + Spouse _____ EE + Child(ren) _____ Family _____

Current or Requested Plan Design _____

Dental

Employer Paid

Voluntary

Annual Max

\$1,000 \$1,500 \$2,000

\$3,000 \$5,000

\$100 Lifetime Deductible

\$50/\$150 Calendar Year Deductible

\$25/\$75 Calendar Year Deductible

\$0/\$0 Deductible

Additional Options

Endo/Perio to Basic 2 year rate guarantee

Composite (white) Adult and Child
Fillings Upgrade Ortho

Child Ortho Other Options

No Waiting Periods

Vision

Employer Paid

Voluntary

Frequency

Materials Only

12/12/24

12/12/12

Co-Pay

\$10/\$0

\$10/\$10

\$10/\$25

Other Options

*For Groups with 50+ members please submit a census for custom quoting to AgentSupport@DirectBenefits.com or call us with questions at (800) 620-5010 x 5



Date _____ Date Needed _____

Group Name _____

City _____ State _____ Zip Code _____

Nature of Business or SIC Code _____ Requested Effective Date _____

of Eligible Employees* _____ Employer Paid _____ Partial Employer Contribution _____ Voluntary _____

Comments or Special Requests _____

Please complete all sections applicable to the coverages for which you are requesting a proposal.

Producer's Name as to Appear on Proposal _____

Agency Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Email Address _____

Group Census Information

Are Employees 50% Family Related? Yes No

	Age/ DOB	Gender	Salary/ Wages	Occupation		Age/ DOB	Gender	Salary/ Wages	Occupation
1					6				
2					7				
3					8				
4					9				
5					10				

For groups with 10+ eligible employee, please send/email a complete census to AgentSupport@DirectBenefits.com

Life/ AD&D

Flat Amount: \$ _____ on all Full-time Employees

Multiple of Earnings _____ X earnings on all employees to a max of \$ _____

Class plans (list benefits below)

STD

Flat Amount: \$ _____ /week on all Full-time employees

Percent of Earnings _____ % of Earnings to a max benefit of \$ _____ /week

Short Term Disability Benefits Duration
13 weeks 26 weeks

LTD

Percent of Earnings _____ % of Earnings to max benefit of _____ /month

Elimination Period

60 days 90 days 180 days

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