



A Broker Information

CHECK IF NEW ADDRESS

BROKER CODE (IF KNOWN) **69874**

AGENT NAME **GREG STENZEL**

AGENCY **STENZCO INSURANCE SERVICES**

ADDRESS **21151 S WESTERN AVE SUITE 263**

CITY **TORRANCE**, CA ZIP **90501**

PHONE (**310**) **212-5566** FAX (**888**) **454-5148**

DELIVERY OF PROPOSAL:

- WILL PICK UP
- MAIL COMPLETE PROPOSAL
- HAVE REPRESENTATIVE CALL
- EMAIL COMPLETE PROPOSAL TO: _____

FAX COMPLETED FORM TO: 888-454-5148

B Group Information

COMPANY NAME _____

STREET ADDRESS _____
(NO P.O. BOX)

CITY _____, CA ZIP _____

1. NATURE OF BUSINESS _____ → **SIC CODE** _____

2. LEGAL STRUCTURE OF THE BUSINESS:

CORPORATION PARTNERSHIP S CORPORATION

SOLE PROPRIETOR OTHER _____

3. CURRENT MEDICAL CARRIER _____

CURRENT MONTHLY PREMIUM _____

PLAN TYPE: HMO PPO MULTI/OPTION

4. DOES GROUP CURRENTLY HAVE A DENTAL PLAN? YES NO

NAME OF DENTAL CARRIER _____

5. REQUESTED EFFECTIVE DATE _____

6. # OF ELIGIBLE EMPLOYEES* _____

7. # OF PART-TIME EMPLOYEES _____

AT LEAST 70% OF ELIGIBLE EMPLOYEES MUST ENROLL. SEE UNDERWRITING GUIDELINES FOR DETAILS.

8. OUT-OF-STATE EMPLOYEES? YES NO
(IF YES, PLEASE COMPLETE OUT-OF-STATE CENSUS ON BACK)

9. % OF COSTS TO BE PAID BY EMPLOYER:

_____ % EMPLOYEE COSTS

_____ % DEPENDENT COSTS

EMPLOYER MUST CONTRIBUTE A MINIMUM OF 50% OF THE LOWEST COST EMPLOYEE PREMIUM AVAILABLE

C Life Insurance Enrollment Information

Choose one of two methods below

Coverage limits available for both methods	ELIGIBLE EMPLOYEES	GUARANTEED ISSUE	
		MINIMUM	MAXIMUM
	2-10	\$10,000	\$25,000
	11-25	\$10,000	\$50,000
	26-50	\$10,000	\$75,000

METHOD 1:

EMPLOYER MAY SELECT A FLAT AMOUNT OF INSURANCE STARTING AT \$10,000 AND INCREASING BY INCREMENTS OF \$5,000 TO THE MAXIMUM AMOUNT ALLOWED FOR THE NUMBER OF ELIGIBLE EMPLOYEES (SEE CHART). INDICATE NUMBER OF ELIGIBLE EMPLOYEES AND FLAT AMOUNT BELOW:

OF ELIGIBLE EMPLOYEES: _____ FLAT AMOUNT: _____

To obtain life coverage, ALL full time employees enrolling in or waiving medical must be covered

METHOD 2:

EMPLOYER MAY SELECT UP TO 4 CLASSIFICATIONS OF INSURANCE COVERAGE IN \$5,000 INCREMENTS, WITH THE HIGHEST AMOUNT NO MORE THAN 2.5 TIMES THE LOWEST AMOUNT SELECTED:

LOWEST AMOUNT: \$ _____ ^{\$5,000 INCREMENTS ONLY} X 2.5 = HIGHEST AMOUNT: \$ _____ ^{\$500 INCREMENTS O.K.}

PLEASE ENTER UP TO 4 LIFE COVERAGE AMOUNTS THAT INCLUDE AND/OR FALL WITHIN THE MINIMUM AND MAXIMUM AMOUNTS ABOVE & EMPLOYEE CLASSIFICATION (i.e. EXECUTIVE, MANAGEMENT, HOURLY, ETC.) FOR EACH:

LIFE AMOUNT	EMPLOYEE CLASSIFICATION LEVEL TO BE OFFERED THIS AMOUNT
\$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____

D	Census Information		SEX (M/F)	DATE OF BIRTH (MO/DAY/YEAR)	DEPENDENTS		IF ON COBRA	HOME ZIP CODE	LIFE AMOUNT (\$)
	LAST	FIRST			✓ IF SPOUSE	# OF CHILDREN			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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21									
22									
23									
24									
25									

REQUIRED!

E	Out-of-State Census Information		SEX (M/F)	DATE OF BIRTH (MO/DAY/YEAR)	DEPENDENTS		IF ON COBRA	WORK ZIP CODE	LIFE AMOUNT (\$)
	LAST	FIRST			✓ IF SPOUSE	# OF CHILDREN			
1									
2									
3									
4									
5									

REQUIRED!