



## WBACC TRUST Request for Proposal

Group Name		Industry	
City, Zip, County		SIC Code	Renewal Date
Effective Date			
Current Medical Carrier			
No current group medical coverage <input type="checkbox"/>			
Current Plan Design: <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO			
Co-Pay: \$ _____ Co-Insurance: % _____ Deductible: \$ _____			
Out of Pocket Max: \$ _____ Pharmacy Co-Pay: \$ _____			
EE Only	Current Rates \$ _____	Renewal Rates \$ _____	
EE & Spouse	\$ _____	\$ _____	
EE, Spouse & Child(ren)	\$ _____	\$ _____	
EE & Child(ren)	\$ _____	\$ _____	
Current Dental Carrier			
No current group dental coverage <input type="checkbox"/>			
EE Only	Current Rates \$ _____	Renewal Rates \$ _____	
EE & Spouse	\$ _____	\$ _____	
EE, Spouse & Child(ren)	\$ _____	\$ _____	
EE & Child(ren)	\$ _____	\$ _____	
Employer Contribution			
Medical:    Employee _____ %    Dependents _____ %			
Broker Name: _____			
Agency: _____			
Phone Number: _____ Fax Number: _____			
Email Address: _____			