

# HORIZON BENEFITS GROUP

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## GROUP INSURANCE PROPOSAL REQUEST

TARGET EFFECTIVE DATE: \_\_\_\_\_

Give us an opportunity to **Shop the Insurance Marketplace** on your Behalf.

We are **Independent Brokers** representing most major insurance companies -- PPO's, HMO's and Freedom of Choice Plans.

Complete and return this form, along with a census for a comprehensive **No Obligation Quote**.

### CURRENT CARRIER

Current Carrier:

Current Plan Renewal Date:

Reason for considering Alternative Plans:

### BENEFITS DESIRED

Plan Style:  PPO  HMO

FREEDOM OF CHOICE PLANS

MD Copay:  \$10  \$15  \$20

Deductible:  \$100  \$250  \$500  \$1,000

Dental:  Include  Exclude

Disability

Short Term:  Include  Exclude

Long Term:  Include  Exclude

Wellness Bene:  Include  Exclude

Life Insurance:  Include  Exclude \_\_\_\_\_ Amount

### GENERAL INFORMATION

Group Name:

Address:

Phone Number:

Contact Person:

Nature of Business:

### **To the best of your knowledge -**

Do you know of any employee, dependent or COBRA participant, that has been diagnosed or treated in the past 5 years for:

Heart Disease

Stroke

Diabetes

Seizures

Kidney Disease/Failure

Back Disorders

Chronic Lung Disorder

Cancer

AIDS/HIV+

Drug/Alcohol Abuse

Mental/Nervous Disorder

Muscular Dystrophy

Multiple Sclerosis

Lupus

Rheumatoid Arthritis

Congenital Disorders

Growth Hormones

Intestinal Disorders

Liver Disorders

Organ Transplants

Connective Tissue Disorder

Any current Pregnancies? (If so list delivery date, and any complications, including multiple births.)

Are any Employees or Dependents receiving disability benefits of any type?

Any Employees absent from work, or confined to home for more than 2 consecutive weeks due to injury or sickness?

Any Employees or Dependents that have been advised to undergo medical treatment, surgical operations, diagnostic testing or Hospitalization in the next 6 months?

Any Employees or Dependents that have been hospitalized in the past 5 years?

If "YES" to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_