



REQUEST FOR PROPOSAL

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P.O. BOX 32625 SHREVEPORT, LA 71130

Company Name: _____ Date Submitted: _____
Address: _____ Phone No.: _____
Contact Person: _____ Other Locations: _____
Type of Business: _____ SIC: _____ Effective Date: _____

CURRENT CARRIER or SELF FUNDED?

How Long: _____

Current Plan: _____
(Attach summary for comparison)

Current Rates per Month:

EE _____ EC _____

ES _____ EF _____

ELIGIBILITY

Total Employees *Employed* _____

Employees *Eligible* for Plan _____

Employees *Participating* _____

Cobra / State Continuation Participants _____

Retiree Participants _____

Out of Area Participants _____

MEDICAL

- Has any participant been treated for any of the following within the last 5 years?
 Cancer or Kidney Ailments ____ Diabetes or Heart Problems ____
 Mental/Nervous, Substance Abuse ____ On-Going Disabilities ____
 Current Pregnancies/ Due Date ____ Immune System Disorders ____
 Any Known Scheduled Surgeries/Treatments ____
- Has any employee missed 10 or more consecutive days of work for health conditions? If yes, explain: _____
- Large Claims History (List any claims over \$2,500. for groups 2-24 or \$10,000 for groups in the last 12 months). Provide details for any on-going conditions.
- Attach claims experience for Large Group Quotes. (Self-funded groups must furnish 12 months of claims history).

Submit Census Including: Date of Birth, Spouse Date of Birth, Age, Sex , Number of Dependents, Employee Status and Location for all Participants.

Agent Name _____ Phone # _____
Fax # _____

BENEFIT PLAN SELECTIONS