

# HEALTHY BASICS REQUEST FOR PROPOSAL FORM

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## PROSPECT INFORMATION

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

Contact Person: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Description of Operation or Business Type: \_\_\_\_\_

Number Of Eligible Employees \_\_\_\_\_ Employer Contribution: \_\_\_\_\_ %  
 (Note: Employer contribution of 50%+ toward employee only premium will lower plan rates)

## PLAN & PLAN OPTIONS REQUESTED -- Check box to indicate choice(s) If no options are requested, circle standard plan(s) requested.

### PLAN SELECTION

|                              | Plan 200 | Plan 300 | Plan 500 | Plan 700 | Plan 1000 |
|------------------------------|----------|----------|----------|----------|-----------|
| First Day Hospital Admission |          |          |          |          |           |
| Anesthesia Benefit           |          |          |          |          |           |
| Short Term Disability        |          |          |          |          |           |
| Dental & Vision              |          |          |          |          |           |
| \$ 250 Annual Max. Benefit   |          |          |          |          |           |
| \$ 500 Annual Max. Benefit   |          |          |          |          |           |
| \$1,000 Annual Max. Benefit  |          |          |          |          |           |

### SPECIAL REQUESTS OR INSTRUCTIONS:

(All plans will include a PPO Network unless otherwise requested)

## AGENT INFORMATION

Agency: \_\_\_\_\_

Agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

## CUSTOM BENEFIT PLAN REQUEST – Indicate Benefit Requested

(Plan benefits available may depend upon employer contribution. Proposals will be provided illustrating available benefits as close as possible to request. All proposals subject to final underwriting approval. )

|                                  |                       |  |
|----------------------------------|-----------------------|--|
| Life, AD & D                     | \$ _____              | From \$5,000 (Mandatory) to \$50,000 - \$5,000 Increments  |
| Dependent Life                   | \$ _____              | Level I - (Standard) (\$2,500 Spouse/\$1,250 Child(ren))<br>Level II - \$ 5,000 Spouse, \$2,500 Child(ren)<br>Level III - \$ 7,500 Spouse, \$3,750 Child(ren)<br>Level IV - \$10,000 Spouse, \$5,000 Child(ren)<br>Level V - \$12,500 Spouse, \$6,250 Child(ren) |
| Hospital Indemnity               | \$ _____              | From \$100 to \$1,000 a Day / 2 x Limit for ICU (\$100 Increments)   |
| 2X First Day Indemnity           | Yes    No             | Benefit will be 2 times the daily hospital benefit for 1 <sup>st</sup> . admission   |
| Doctor Office Visit              | \$ _____              | From \$10 - \$75 Per Visit Indemnity   |
| Max. Annual Limit                | \$ _____              | \$30, \$330, \$360, or \$450 Per Person  |
| Outpatient Diagnostic            | _____                 | \$20/70/C/ Max \$1,200 (OP Lab / OP X-ray / Schedule / Advanced Studies)   |
|                                  | _____                 | \$20/70/C/ Max \$2,400 (OP Lab / OP X-ray / Schedule / Advanced Studies)   |
|                                  | _____                 | \$35/100/B/Max \$1,305 (OP Lab / OP X-ray / Schedule / Advanced Studies)   |
|                                  | _____                 | \$35/100/ B/Max \$2,610 (OP Lab / OP X-ray / Schedule / Advanced Studies)  |
|                                  | _____                 | \$50/150/A/Max \$1,450 (OP Lab / OP X-ray / Schedule / Advanced Studies)   |
|                                  | _____                 | \$50/150/A/Max \$2,900 (OP Lab / OP X-ray / Schedule / Advanced Studies)   |
| Short Term Disability            | \$ _____              | \$ 300 Max. Wkly Benefit   |
| Accident                         | \$ _____              | \$ 300, \$500, \$1,000, or \$2,500 Per Occurrence  |
| Surgical Indemnity               | \$ _____              | From \$400 - \$3,500 Per Calendar Year   |
| Anesthesia Indemnity             | \$ _____              | 25% of Surgical Benefit  |
| Wellness Benefit Maximum         | \$ _____ / _____      | From \$ 50 - \$150 Per Visit / \$150, \$225, \$300 or \$450  |
| Dental Program (Includes Vision) | _____                 | Option I: \$ 50 Deductible / \$ 250 Ann. Max. Per Person<br>Option II: \$ 50 Deductible / \$ 500 Ann. Max. Per Person<br>Option III: \$ 50 Deductible / \$1,000 Ann. Max. Per Person   |
| Patient Advocacy                 | <input type="radio"/> | Program that assists employees in understanding their benefits, select a healthcare provider, schedule appointments & resolve any medical billing issues.  |

**Prescription Drug Programs: (Check Only One)**

- \$5 Co-Pay Generic / \$15 Oral Birth Control / \$400 per month per person maximum benefit. Discount Plan for Brand Name Drugs with no limit on the number of prescriptions discounted.
- \$10 Co-Pay Generic / Discount Brand
- Drug Discount Only Plan