Word&Brown.
General Agency
Service of Unequalled Excellence

PROPOSAL REQUEST

Broker Information

Broker Name

Agency

Address

City , **CA** Zip

☐ Check if new address

Broker Code (if known) Broker License #

Phone ( )

Fax ( )

Email Address

Business / Group Information

Information in this box is required!

Company Zip

Nature of Business

Number of full-time employees (30+ hours/week)

% of costs to be paid by Employer

% of Employee costs % of Dependent Costs

Type of Employees to be quoted

☐ All ☐ Non-Union

Desired Effective Date / /

1. Company Structure
   ☐ Sole Proprietor ☐ Corporation
   ☐ LLC ☐ Partnership ☐ Other
2. More than one location? ☐ Yes ☐ No
   If yes, where?
3. Any employees paid by commission (and/or) paid as independent contractors? (FORM 1099) ☐ Yes ☐ No
   Most current DE-9C available? ☐ Yes ☐ No
   How many weeks payroll?
4. Any COBRA participants previously employed by you? ☐ Yes ☐ No
   (If yes, indicate Zip Code on Census located on reverse side)
5. Employees living Out-of-State? ☐ Yes ☐ No

Proposal Type

- ☐ **Summary Proposal**–Summary of All Plans or Selected Carriers
- ☐ **Custom Proposal**–Select Plans for Benefit & Rate Details
- ☐ **Employee Choice**–Assign plans to employees for a blended rate
- ☐ **California*Choice***
- ☐ **Choice Builder**

Products

☐ **All**
☐ **Medical**

Plan Designs

☐ **All** ☐ **HMO** ☐ **HRA** ☐ **HSA**
☐ **PPO** ☐ **POS** ☐ **Specific Plans (indicate below)**

☐ **Dental**
☐ **Prior coverage**

Plan Designs

☐ **DHMO** ☐ **EPO** ☐ **Indemnity** ☐ **DPO**

☐ **Life** ☐ **Vision** ☐ **LTC** ☐ **LTD** ☐ **STD**

Specific Plans:

1.
2.
3.

Current Coverage Information

Current Health Plan

Current Premium

Current Plan Type ☐ HMO ☐ PPO ☐ EPO ☐ HSA ☐ POS

Are you with a PEO? ☐ Yes ☐ No

Does group have current dental coverage? ☐ Yes ☐ No

If yes, # of years % participation

Delivery Options

☐ Pick-up (check location):
☐ Orange ☐ San Diego ☐ Los Angeles ☐ San Jose ☐ Inland Empire

☐ Email to:

☐ Mail complete proposal

☐ Fax to: ( )

☐ Have Representative call me at: ( )

Fax completed census to office nearest you:

Endsure.com
Email to gary@endsure.com
Toll Free (866) 720-4082
FAX (323) 291-7789

721 South Parker Street ■ Orange, CA 92868 800.869.6989
3633 Inland Empire Blvd., Suite 525 ■ Ontario, CA 91764 877.225.0988
801 North Brand, Suite 900 ■ Glendale, CA 91203 800.560.5614
1737 North First Street, Suite 680 ■ San Jose, CA 95112 800.255.9673
3131 Camino Del Rio North, Suite 820 ■ San Diego, CA 92108 800.397.3381

Company Name: _____

Broker Name: _____

Fax completed census to office nearest you:

Orange	714.347.3878
Inland Empire	909.945.3339
Los Angeles	800.355.9711
Northern California	800.717.7223
San Diego	619.299.2070

Fill in the columns below. Fields marked with an asterisk (*) are mandatory.

1. Enter the Employee first, then every other family member (spouse and children) to be covered on subsequent lines. The Employee ID should be entered sequentially and the same number should be used for each family member. Each person's Date of Birth is mandatory for quoting.
2. After the full family is entered, the next Employee should be started on the following lines. Do not skip a line between employees.

Covered Member Key	
E or 1 =	Employee
S or 2 =	Spouse/Domestic Partner
D or 3 =	Other Dependents

PLEASE NOTE: Every person to be covered is rated individually. Rates vary by age and any change in the date of birth of an employee, spouse or dependent will cause the quoted rates to be different. Any change to the ZIP code and/or number of dependents can also cause the rates to be different.

Census

Employee ID	Covered Member Code (See Key above) *REQUIRED*	Last Name	First Name	ZIP Code Employee Only *REQUIRED*	Gender (M/F)	Date of Birth (mm/dd/yyyy) *REQUIRED*	EE on COBRA? (Y/N)
1	E	Doe	John	90000	M	09/19/1968	N
1	S	Doe	Jane	90000	F	10/07/1969	N
1	D	Doe	Tom	90000	M	12/15/2000	N

Email Request