



# Brokers Insurance Corp

## Health Insurance Proposal Checklist

---

To receive your proposal, please submit the following:

- Completed Health Insurance Proposal & Request – Completed by company representative
- Complete the Employee Census form using the enclosed grid - Completed by company representative
- Copy of Plan Design from current Health Insurance Carrier
- Copy of Most Recent Billing statement from current Health Insurance Carrier

Brokers Insurance Corp must receive these items before a proposal can be sent. If you have questions, please feel free to contact us at 800-227-8711 or 314-961-7077. Your completed proposal can be sent to us in the following ways:

**Mail:** 9201 Watson Road, Ste 300  
St. Louis, MO 63126

**Fax:** 314-919-2096

**E-Mail:** [slove@bicins.com](mailto:slove@bicins.com)

## HEALTH INSURANCE PROPOSAL & REQUEST

### Employer Census

Association/Group Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Nature of Business/SIC Code: \_\_\_\_\_

Desired Effective Date: \_\_\_\_\_

How many employees does your company employ?

Total Number of Employees: \_\_\_\_\_

Total Number of Full-Time Employees: \_\_\_\_\_

Is insurance currently offered to your employees?  YES  NO

Current Carrier: \_\_\_\_\_

Number of Employees on Current: \_\_\_\_\_

Current Monthly Premium: \_\_\_\_\_

Current Deductible: \_\_\_\_\_

Current Office Visit Copay: \_\_\_\_\_

Please Check all that should be included in Proposal:

- |                                 |   |
|---------------------------------|---|
| <input type="checkbox"/> Health | <input type="checkbox"/> Disability       |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Accident         |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Critical Illness |
| <input type="checkbox"/> Life   | <input type="checkbox"/> Wellness         |

**Please include a copy of your current carrier's bill as well as your current plan design.**

**See the next page for an Employee Census form. Please complete in its entirety.**

## GROUP CENSUS FORM

	Employee Name	M/F (circle one)	Employee Age/DOB	Spouse Age/DOB	# Children	Coverage (see codes below)	Salary (for STD/LDT)
1.		M / F				EE EE+SP EE+CH FAM	
2.		M / F				EE EE+SP EE+CH FAM	
3.		M / F				EE EE+SP EE+CH FAM	
4.		M / F				EE EE+SP EE+CH FAM	
5.		M / F				EE EE+SP EE+CH FAM	
6.		M / F				EE EE+SP EE+CH FAM	
7.		M / F				EE EE+SP EE+CH FAM	
8.		M / F				EE EE+SP EE+CH FAM	
9.		M / F				EE EE+SP EE+CH FAM	
10.		M / F				EE EE+SP EE+CH FAM	
11.		M / F				EE EE+SP EE+CH FAM	
12.		M / F				EE EE+SP EE+CH FAM	
13.		M / F				EE EE+SP EE+CH FAM	
14.		M / F				EE EE+SP EE+CH FAM	
15.		M / F				EE EE+SP EE+CH FAM	
16.		M / F				EE EE+SP EE+CH FAM	
17.		M / F				EE EE+SP EE+CH FAM	
18.		M / F				EE EE+SP EE+CH FAM	
19.		M / F				EE EE+SP EE+CH FAM	
20.		M / F				EE EE+SP EE+CH FAM	
21.		M / F				EE EE+SP EE+CH FAM	
22.		M / F				EE EE+SP EE+CH FAM	
23.		M / F				EE EE+SP EE+CH FAM	
24.		M / F				EE EE+SP EE+CH FAM	
25.		M / F				EE EE+SP EE+CH FAM	
26.		M / F				EE EE+SP EE+CH FAM	