Better Benefits, Inc.

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New York, NY 10001-2507
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E-mail: proposals@betterbenefits.com

Request for Rates / Proposal

Broker Information: **BBi Regional Vice President:**_____

Broker / Agent:_____ Company:_____

Address:_____ Phone:_____ Fax:_____

City:_____ State:_____ Zip:_____

Client Information:

Company:_____ SIC Code/Nature of business:_____

Address:_____ Phone:_____ Fax:_____

City:_____ State:_____ Zip:_____

Total Number of Benefit-Eligible Employees:_____

Eligibility period for new employees (e.g. 1st of the month following 90 days of employment) _____ days

Employee Information:

Census – Please submit a benefit-eligible census, preferably in electronic format, which includes the following: employee age (or DOB), gender, date of hire, salary or hourly wage, ZIP code of their work or home location.

Location(s) – If multiple locations, please provide the number of EE's at each work location (3-digit ZIP codes)

Benefits Requested:

❑ Benefits Portfolio – Includes Health Indemnity, Dental, Life, STD and Discount Card

❑ Selected Benefits[1] – Check those requested:

❑ Health Indemnity ❑ Dental ❑ Life ❑ STD ❑ Discount Card ❑ Critical Care/Life

Date Information:

Date Proposal Needed:_____

Plan Effective Date* – New Lives:_____ Existing Lives:_____

Enrollment Start Date* – New Lives:_____ Existing Lives:_____

*** Must be at least 30 days prior to Effective Date**

Payroll Information:

Payroll Mode: ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Semi-Monthly

Last Payroll Deduction Date for Old Plan:_____

First Payroll Deduction Date for Covered Existing Employees*:_____

First Payroll Deduction Date for Covered New Employees**:_____

Updates to Payroll Deduction ❑ Electronic Interface with Payroll ❑ Secure Internet Site

Section 125? ❑ Yes ❑ No

Employer can handle increased payroll deductions for employees missing 1-2 weeks of premium? ❑ Yes ❑ No

*** Must be prior to Effective Date or increase in premium required**

****Must be prior to Effective Date**

Completed form and associated documents should be e-mailed to: info@betterbenefits.com, faxed to (212) 465-1163 or mailed to BBi.

[1] Full enrollment support requires either Medical or Dental to be included.

Enrollment Method: Please choose one

❑ **Active**
- ❑ (A) BBi Standard Outbound to Work Location
- ❑ (B) In-Person Mandatory One-on-One at Work Locations
- ❑ (C) Broker to Perform Mandatory One-on-One with Our Computers
- ❑ (D) Broker to Perform Mandatory One-on-One with Paper Applications
- ❑ (E) Mandatory In-Bound Telephone, Supplemented with Outbound Calls to Stragglers
- ❑ (F) Train-the-Trainer at Stores with Mandatory Complete Paper Application

Please note, above methods will guarantee no minimum participation requirements

❑ **Passive**
- ❑ (A) Mail to Employee's Home
- ❑ (B) Mail to Worksite
- ❑ (C) Payroll Stuffers
- ❑ (D) Employee Newsletter
- ❑ (E) Internet Enrollment
- ❑ (F) Train-the-Trainer with Voluntary Submission of Applications
- ❑ (G) Voluntary In-Bound Calls
- ❑ (H) Broker Does Group Meeting, Voluntary Attendance

Note, passive enrollments have minimum 20% participation for each product.

Health Indemnity Plan:

❑ Virgin ❑ Single Plan ❑ PPO Requested (High only, both plans)
❑ Takeover ❑ Hi/Lo Dual Choice ❑ Patient Advocate Requested (High only, both plans)

If Takeover: Original effective date of prior plan_____ Number of Rollover Lives:_____

Please Enclose Copy of Current Plan

Employer Contribution ❑ Yes ❑ No
(If yes, please advise $$ amount or percentage)
$_____ **or** _____%

Current Rates:

Member	Rate
Employee	$_____/month
_____	$_____/month
_____	$_____/month

Dental Plan:

❑ Virgin ❑ Takeover

If Takeover: Original effective date of prior plan_____ Number of Rollover Lives:_____

Please Enclose Copy of Current Plan & Experience

Hi/Lo Requested[1]: ❑ Yes ❑ No
Ortho Requested: ❑ Yes ❑ No
Annual Maximum: ❑ $1000 ❑ $1500
Deductible: ❑ $50 ❑ $75 ❑ $100
❑ 100/50/50 ❑ 100/80/50
PPO Required: ❑ Yes ❑ No

Member	Current Rate	Renewal Rate
Employee	$_____/month	$_____/month
_____	$_____/month	$_____/month
_____	$_____/month	$_____/month

Administration Requested:

COBRA for Medical and Dental ❑ Yes ❑ No
Payroll: ❑ Weekly ❑ Bi-weekly

Short Premium Administration	Sec 125	
Back-bill Employer	Yes	❑
Terminate EE after 4 cum. wks short	Yes	❑
Bill EE and Term. EE after 6 cum. wks short	Yes	❑

–BBi Use Only–

Request Received:_____ In Pursuit:_____
In CaseTrac:_____ Date Run:_____
Proposal Prep. Date:_____ Final Disposition:_____
Rates by:_____

[1] Available only to 100+ Eligible Lives