Church Benefits Board
2930 Flowers Road, Suite 133A
Atlanta, GA 30341
Toll Free: 800-352-8741
Fax: 770-220-1685
Email: Info@FellowshipTravel.org

REQUEST FOR PROPOSAL

Mission Name_______________________________________ Telephone______________________
Street Address_____________________________________ Contact Person__________________
City______________________________ State________ Country_________ Postal Code___________
Desired Effective Date_________________

What is the employee and/or self-employed filing status with the IRS?
(Check all boxes that apply) ☐ W-2 ☐ 1099 ☐ No Compensation

BENEFIT PLANS DESIRED

Deductible Requested ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000
Lifetime Maximum ☐ $1,000,000 ☐ $5,000,000
Life Insurance ☐ $25,000 ☐ $50,000 ☐ Other Amount___________

Agency_____________________________ Agent Name________________ Agent #________________
Address______________________________ City_____________ State _______ Country____________
Telephone____________________________ Fax________________ Email________________________

Does applicant presently have group medical insurance? ☐ Yes ☐ No
If yes, please attach the following:

1. Copy of present policy and/or booklet describing benefits.
2. Copy of most recent billing statement from present carrier.
3. Copy of most recent 3 years claims experience.
   (In most instances, this can be obtained from your present and/or past carrier(s))

Total number of full-time and part-time employees ____________ **Total number of eligible employees & appointed representatives** _____________ (including U.S.-based and international employees)
Member Category (provide account) -
1. **Employees, work more than 30 hours a week** ____________
2. **Volunteers** __________________
3. **Self-Employed** __________________

Has another insurance carrier refused your group? ☐ Yes ☐ No
How many covered employees and appointed representatives have been employed less than six months? ________
Do you expect the number of covered persons to vary by more than 10% during the next 12 months? ☐**Yes** ☐ **No**
If yes, please explain:____

Does your group offer COBRA? ☐ Yes ☐ No
Are any covered persons presently on COBRA?☐ Yes ☐ No
(If yes, please list names and the date COBRA began along with the qualifying event. Attach additional sheets if necessary).
Name____ Date Cobra began___________
Name____ Date Cobra began___________
Name____ Date Cobra began___________

Please answer the following questions. If your answer to any of these questions in yes, please provide details in the space provided below.

1. Has any person to be covered under this plan, including dependents suffered from a condition which resulted in a claim of $2,500 or more during the last 3 years? ☐ Yes ☐ No
2. Is any person to be covered under this plan, including dependents currently pregnant? ☐ Yes ☐ No
3. Is any person to be covered under this plan, including dependents presently hospitalized, Confined at home or treatment facility, disabled or incapacitated? ☐ Yes ☐ No
4. Is there any person under this plan, including dependents not actively at work performing his/her normal duties due to illness or injury? ☐ Yes ☐ No
5. Are you aware of any circumstances, chronic or continuing medical, mental or Nervous conditions which can be expected to produce ongoing claims? ☐ Yes ☐ No

Additional Comments: (attach additional sheets if necessary)

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Employee Census: It is important that each person to be covered be included on this census. The initial quotation is based on this census. Final rates are based on actual enrollment.

Sex	Name	Pay Type*	Status**	Date of Birth	Hire Date	Annual Salary	Country of Residence

Provide Names of any U.S. Veterans: ____

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*** Pay Type: Employee (E) Volunteer, Self Employed Contractors or other Non-Compensated Mission Affiliates (V)**
**** Status: Primary Insured (E) Spouse (S) Dependent Child (D)**

The information provided on this form, including attachments, is intended to provide the company with information necessary to evaluate your group and provide you with premium and coverage indications. Final rates and coverage will be based on the actual enrollment, including evidence of insurability' if applicable. No insurance is in effect unless you are notified in writing by the company.

Applicant Signature ____ Date ____________________

Agent Signature ____ Date ____________________