

**Borshoff & Associates**

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GROUP PROPOSAL FORM**Company Information**

Company Name	
Address	
City	
State	
Zip	
Nature of Business	
SIC Code	
Type of Business	<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other

Life Insurance Options

Total Coverage Options	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	<input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> _____	
Length of Coverage	<input type="checkbox"/> 1 year <input type="checkbox"/> 5 years <input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years <input type="checkbox"/> 30 years <input type="checkbox"/> _____	
Type of Coverage	<input type="checkbox"/> Term <input type="checkbox"/> Permanent		
Life & AD&D _____ Flat Amount \$ _____ Per Employee _____ Based on Salary <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x _____ Classed Benefits (Up to 3 Classes)	Weekly Income Option <input type="checkbox"/> 1-8-26 weeks <input type="checkbox"/> 15-15-26 weeks _____ Flat Amount \$ _____ Per Week _____ % of Salary _____ Classed Benefits (Up to 3 Classes)		
	Description/Occupation	Life & AD&D	Weekly Income
Class 1			
Class 2			
Class 3			
<i>Note: Salaries must be listed on census for benefits based on earnings.</i>			

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Health Insurance Options

Deductible <i>(Groups of 2-14 choose one deductible. Groups of 15+ may choose up to three.)</i>	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> _____
Benefit Percentage	<input type="checkbox"/> 100/70% <input type="checkbox"/> 90/80% <input type="checkbox"/> 90/70% <input type="checkbox"/> 90/60%	<input type="checkbox"/> 80/60% <input type="checkbox"/> 80/50% <input type="checkbox"/> 70/50% <input type="checkbox"/> _ / _ %
Benefit Percentage Limit	<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$_____
Co-Payment Option	<input type="checkbox"/> \$10 <input type="checkbox"/> \$20	<input type="checkbox"/> \$30 <input type="checkbox"/> \$_____
Preventive Care Option	<input type="checkbox"/> Yes \$_____ amount	<input type="checkbox"/> No
Maternity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supplemental Accident	<input type="checkbox"/> Yes \$_____ amount	<input type="checkbox"/> No
Mental Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deductible Carryover	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24 Hour Occupational Coverage <i>(Applies to both Medical and Dental)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription Drug Card	<input type="checkbox"/> Yes \$_____ Generic \$_____ Name Brand	<input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> With Ortho <input type="checkbox"/> Without Ortho	<input type="checkbox"/> No
Did you have Prior Dental Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No