1804 Juan Tabo Blvd. NE, Ste. A
Albuquerque, NM 87112
(505) 237-1501 / 888-862-8659

Request for Proposal (RFP)

Dental, Vision, Life, STD, LTD

Thank you for selecting BenefitSource to assist you in choosing benefits that best fit your client's needs. Please complete first page and all sections on page 2 applicable to the coverages for which you are requesting a proposal. Please attach a census (excel format to include- gender, date of birth, occupation and salary), current plan design, experience information and rates.

Date:		Due Date:		Requested Effective Date:	

Group Name:				SIC Code/ Type of Business:	
Group Address:					
City:		State:		Zip:	
Years in Business:		Tax ID Number:			
# of Eligible Employees:		Eligible employees must work # of hrs/wk:			
Wait period for new hires:		Are there existing benefits?		☐ Y ☐ N	

Agency Name:			
Agent Name:			
Email:		Are you the Broker of Record?	☐ Y ☐ N
Phone:		Fax:	

Please check all products to be proposed and fill out page 2:

☐ **Dental** ☐ **Vision**

☐ **Life AD&D*** ☐ **STD*** ☐ **LTD***

***Complete excel census required for all Life/STD/LTD Products**

Additional Comments:	

Please submit RFP to sales@benefitsource.org or Fax (505) 237-8344

For Questions regarding this RFP please contact BenefitSource at (505) 237-1501 or 888-862-8659

Please provide a current summary of benefits for all existing plans you wish to match benefits.

Dental				**Match Benefits:** ☐ **Yes** ☐ **No**	
Employer Contribution:	☐ Voluntary			☐ Contributory/ Employer Paid	
Tier Rate	☐ 2-Tier		☐ 3-Tier		☐ 4-Tier
Annual Maximum:	☐ $1000	☐ $1200	☐ $1500 (5+ee's)	☐ $2000(10+ee's)	☐Other________
Indemnity Ortho Benefit:	☐ $1000	☐ $1500	☐ Other__________	☐ Sandia Ortho Edge	
Endo and Perio Services:	☐ Basic ☐ Major	Deductible:	☐$50/$150 ☐$25/$75 ☐ Other:__________	Previous Carrier Name:	
Current Rates	E Only $__________	E+Spouse $_________	E+Child(ren) $__________	E+Family $__________	
Renewal Rates	E Only $__________	E+Spouse $_________	E+Child(ren) $__________	E+Family $__________	

Vision			**Match Benefits:** ☐ **Yes** ☐ **No**	
Employer Contribution:	☐ Voluntary	☐ Contributory/ Employer Paid		
Frequency of Exam, Lenses, Frames (in mos.):	☐ 12/24/24	☐ 12/12/24	☐ 12/12/12	
Material Allowance (Frames or contacts):	☐ $100	☐ $130	☐ $150	☐ Other___________
Copays (Exam/Material):	☐ $10/$15	☐ $15/$15	☐ $10/$25	☐ Other______________
Plan Type	☐ Full Service	☐ Materials-Only	Previous Carrier Name:	
Current Rates	E Only $___________	E+Spouse $____________	E+Family $_____________	
Renewal Rates	E Only $___________	E+Spouse $____________	E+Family $_____________	

☐ **Life AD&D** **Voluntary** ☐ **Yes** ☐ **No**	☐ **STD** **Voluntary** ☐ **Yes** ☐ **No**	☐ **LTD** **Voluntary** ☐ **Yes** ☐ **No**
☐ Flat Amount $_____________on all full time employees	☐ Flat Amount $_____________ / wk on all full time employees	☐ Percent of Earnings _____ % of earnings to $___________ max monthly benefit of full-time employees (standard)
☐ Multiple of Earnings _____ X Earnings on all employees to max of $_____________	☐ Percent of Earnings _____ % of earnings to the max benefit of $_____________	
☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________	☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________	☐ Class Plan (list benefits below) ________________________________ ________________________________ ________________________________ ________________________________
Employer Contribution ________%	Employer Contribution ________%	Employer Contribution ________%
Current Rate ________ per $1000	Current Rate ________ per $10	Current Rate ________ per $100
Renewal Rate ________ per $1000	Renewal Rate ________ per $10	Renewal Rate ________ per $100
LIFE REDUCTIONS	SHORT TERM DISABILITY	Elimination Period: ☐ 90days ☐ 120 days ☐ 180 days ☐ Other________
☐ 35% at 65, Terminate at 70 or retirement (Groups 2-9)	_________ day(s) accident _________ days sickness _________ weeks	Benefit Integration: ☐ Primary & Family (standard) ☐ Primary Only
☐ 35% at 65, 50% at 70, 75% at 75, Terminate at Retirement (Groups 10+)		Benefit Duration: ☐ To Age 65 RBD ☐ 5 Year ☐ 2 Year
☐ Other______________________________	1/8/13 or 1/8/26 (standard)	Own OCC Definition: ☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ To Age 65
Extended Death Benefit (Groups2-9) **Waiver of Premium (Groups 10+)**		
☐ Dependent Life Amount Spouse $__________ Child(ren) $__________		
☐ Life Claims Experience Attached (Groups 150+)	☐ STD Claims Experience Attached (Groups 100+)	☐ LTD Claims Experience Attached (Groups 200+)

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