****

**15301 W 87th St Pkwy, Suite 275** **Phone: 913-631-0102**

**Lenexa, KS 66219 Fax: 913-631-2792**

**Email: office@legacybrokerskc.com**

|  |
| --- |
| **REQUEST FOR PROPOSAL** |

**\*Required Fields For FormFire**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agent Profile** | | | | | |
| Name: |  | | | NPN: |  |
| Phone: |  | Fax: |  | | |
| Email: |  | | | | |
| Address: |  | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Company Profile** | | | | | | | | | | | | |
| \*Name: |  | | | | | | | | | | | |
| \*Physical Address: |  | | | | | | | | | | | |
| \*City, State Zip: |  | | | | | | | | | | | |
| \*County: |  | | | | | | | | | | | |
| \*Industry (SIC/NAICS): |  | | | | \*Tax ID: | |  | | | | | |
| \*Contact Person: |  | | | | | | | | | | | |
| \*Phone: |  | | | Ext: |  | | | Fax: | |  | | |
| \*Email: |  | | | | | | | | | | | |
| Date RFP Received: |  | | | | | | | | | | | |
| \*Proposed Effective Date: |  | | Commission Amt Requested: | | | | | | | |  | |
| Quote Needed By: |  | | | | | | | | | | | |
| Employer Contribution: | Employee (Medical): |  | | | | Dependent (Medical): | | | | | |  |
| Waiting Period: |  | | | | | | | | | | | |
| \*Census: |  Excel File Attached | | \*EE Subscribers: | | | | | |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Products Requested** | | | | | |
|  Fully Insured Medical | |  Dental | |  Long Term Disability | |
|  Self-Funded Medical | |  Vision | |  Worksite / Voluntary | |
|  Life | |  Short Term Disability | |  | |
| **Benefit Levels Requested (Medical)** | | | | | |
| Deductible: |  | | Out-of-Pocket: | |  |
| Office Copays: |  | | Rx Copays: | |  |
| Other: |  | | | | |

|  |  |
| --- | --- |
| **Current / Renewal Benefits & Rates from Current Carrier** | |
|  \*Current Benefits Attached |  \*Current Rates Attached |
|  Renewal Benefits Attached |  Renewal Rates Attached |