Legacy Brokers LLC

REQUEST FOR PROPOSAL CHECKLIST

Small Group (1-50 enrolled)

Small group fully insured plans are not medically underwritten, and generally based on age and zip code. Small group self-funded plans are medically underwritten. We can provide fully insured and self-funded proposals for most small groups.

To request a proposal from Legacy Brokers in the small group market, please complete the information on page 2 of this document, as well as the corresponding RFP Census file (preferably in MS Excel). Remember to include all dependent information for those who intend to enroll. This ensures accuracy of the proposals we generate. Also, be sure to include the following information:

	A copy of the current benefit schedule (SBC document)
	A copy of the current rates (by age or by enrollment tier)
	A copy of the renewal offer from current carrier

Large Group (51 or more enrolled)

Large group rates are generally underwritten. Some large groups receive claims data from the current carrier. In addition to the items listed above for small groups, please include the additional information below when requesting a large group proposal:

	24 months of enrollment count (by month) broken down by plan (if multiple plan designs are offered)
	24 months of rate history
	24 months of paid claims (by month)
	24 months of large claims information (claims over $10,000)
	Diagnosis and Prognosis of any ongoing large claims

The information listed above for large groups is a standard request and may be accompanied by additional information requirements depending on what the carrier requests.

Send all RFP’s to **Sales@LegacyBrokersKC.com**

15301 W 87th St Pkwy, Suite 275
Lenexa, KS 66219

Phone: 913-631-0102
Fax: 913-631-2792
Email: sales@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