# REQUEST FOR PROPOSAL

## Group Information

Group Name: _____

Address: _____ City, State Zip : _____

Current Carrier: _____ | Eligible Employees: #_____ | Desired Effective Date: _____

This group is the Agency's: ☐ Current Client ☐ Prospective Client

## Agent Information

Name: _____ | Agency: _____

Email: _____ | Phone: _____

Are you/your agency currently appointed with Options Plus? ☐ YES ☐ NO

## Plan Options

| MEC Plans | | | | Hospital Indemnity *(Choose Only One)* | |
|---|---|---|---|---|---|
| ☐ BASIC | ☐ ULTRA | ☐ ULTIMATE | ☐ OTHER | ☐ NATIONAL VALUE | ☐ NATIONAL HIGH |

| Dental | | Vision | Worksite* | |
|---|---|---|---|---|
| ☐ PREVENTIVE | ☐ COMPREHENSIVE | ☐ VSP VISION | ☐ CRITICAL ILLNESS | ☐ ACCIDENT |

IF OTHER: _____ ** MEC Required to Offer Benefits*

## Notes

Email RFP request to: service@optionsplusplan.com

**Enrollment Kits Available by Request**