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, Medical Gap, Work-site

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** ☐ **Medical Gap***

☐ **Life AD&D*** ☐ **STD*** ☐ **LTD*** ☐ **Work-Site, CI, AI, Hosp.***

***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_____ **Extended Death Benefit (Groups2-9)** **Waiver of Premium (Groups 10+)**	1/8/13 or 1/8/26 (standard)	Own OCC Definition: ☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ To Age 65
☐ 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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☐ **Medical Gap** **Voluntary ☐ Yes ☐ No**	**Worksite Plans**
☐ Employer contribution %_____ or $_____on all full-time employees	☐ Critical Illness ☐Hospital Indemnity ☐ Accident Expense
In-Hospital Benefit: Plan I: $_____ ☐ $_____ Plan II: $_____ ☐$_____	Employer Contribution _____%
Outpatient Benefit: ☐ OP I: ☐ OP II: ☐ Plan I: $ _____ ☐ Plan II: $_____ Physician Benefit: ☐ Plan I: $_____ ☐ Plan II: $_____ ☐ $15 visit, $120 or 8 visits/family/year ☐ $20 visit, $240 or 12 visits/family/year	

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