SYNDICATED INSURANCE
··········S E R V I C E S, I N C

1580 S. Milwaukee Avenue, Suite 305
Libertyville, IL 60048
Phone: 847.882.7710 Fax: 847.882.7920

PROPOSAL REQUEST FORM

Today's Date ___________________ **Requested Effective Date**___________________

Business Information

Business Name____

Business Street Address____

Business City_________________________ **Business State**_________ **Business Zip Code**______________

Business County_________________________ **Business Phone Number**_________________________

Nature of Business_____________________________________ **Total Number of Employees**_________

Current Plan Information (if group currently has coverage)

Current Carrier______________________ **Renewal Date**______________ **Plan Name**________________

Current Deductible______________ **Current Coinsurance %**________ **Current Out of Pocket**____________

Current Dr. Co-Pay ______________ **Current Rx Co-Pay**________________ **Current Network**____________

Census Information

	Name (Optional)	Date of Birth (DOB)	Sex	Spouse's DOB/Gender (if taking coverage)	Child(ren)'s DOB/Gender (if taking coverage)	Zip Code of Employee
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						