SC ONLY

REQUEST FOR PROPOSAL (RFP)

SHADED AREAS MUST BE COMPLETED

Companion Life Insurance Company • P.O. Box 100102 • Columbia, South Carolina 29202-3102 1-800-753-0404 FAX (803)735-0736

Date ______ Date Needed ______

Please complete all sections applicable to the coverages for which you are requesting a proposal. Complete the other side, or attach census data to this RFP.

Group Name ______

City ______ State ______ ZIP ______

Nature of Business or SIC Code ______

# of Employees ______

Requested Effective Date: ____ / ____ / ____

Current Carrier(s) ______

Comments or Special Requests: ______

Producer's Name as to Appear on Proposal ______

Agency Name ______

Address ______

City ______ State ______ ZIP ______

Phone Number: ( ) ______

☐ Fax Rates to: ( ) ______ Attn: ______

☐ Also Fax Rates to: ( ) ______ Attn: ______

☐ Mail Formal to Producer

BASIC COMMISSION: ☐ STANDARD % FLAT ☐☐

OVERRIDE: ☐ STANDARD % FLAT ☐☐

CLASS DESCRIPTION – Employees in the classes below are to be quoted for the benefits listed at right.

	☐ LIFE AD&D	☐ STD	☐ LTD
	☐ **FLAT AMOUNT** $ ______ on all Full–time Employees ☐ **MULTIPLE OF EARNINGS** ______ x Earnings on all Employees to max of $ ______ ☐ **CLASS PLAN** (List benefits below.)	☐ **FLAT AMOUNT** $ ______ / week on all Full–time Employees ☐ **PERCENT OF EARNINGS** ______ % of Earnings to a max benefit of $ ______ /week ☐ **CLASS PLAN** (List benefits below.)	☐ **PERCENT OF EARNINGS** ______ % of Earnings to $ ______ max monthly benefit on all Full-time Employees (STANDARD) ☐ **CLASS PLAN** (List benefits below.)
Employer Contribution →	______ %	______ %	______ %
Current Rate →	______ Per $1000	______ Per $10	______ Per $100
Renewal Rate →	______ Per $1000	______ Per $10	______ Per $100

LIFE REDUCTIONS

☐ 35% at 65, Terminate at 70 or Retirement (Groups of 2 to 9)

☐ 35% at 65, 50% at 70, 75% at 75. Terminate at Retirement (Groups of 10+)

☐ Other ______

Extended Death Benefit (2-9 Employees)

Waiver of Premium (10+ Employees)

☐ **Dependent Life Amount**
Spouse $ ______
Child(ren) $ ______

☐ Life Claims Experience Attached (Groups of 150 +)

SHORT TERM DISABILITY

______ day(s) accident

______ days sickness

______ weeks
1/ 8/ 13, or 1/ 8/ 26 (Standard)

☐ STD Claims Experience Attached (Groups of 100 +)

ELIMINATION PERIOD

☐ 90 Days ☐ 180 Days
☐ 120 Days ☐ Other ____

BENEFIT INTEGRATION

☐ Primary and Family (Standard)

☐ Primary Only

BENEFIT DURATION

☐ To Age 65 RBD
☐ 5 Year ☐ 2 Year

OWN OCC DEFINITION

☐ 2 Yr. ☐ 3 Yr. ☐ 5 Yr.
☐ To 65

☐ LTD Claims Experience Attached (Groups of 200+)

VOLUNTARY? (LIFE AD&D)	VOLUNTARY? (STD)	VOLUNTARY? (LTD)
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

DENTAL

☐ **DENTAL (10+) Voluntary Dental**

CURRENT RATES		**RENEWAL RATES**	
Employee	$______	Employee	$______
E + 1	$______	E + 1	$______
E + 2	$______	E + 2	$______
Family	$______	Family	$______

Is this Takeover Coverage? ☐ Yes ☐ No

If Yes, total years with Current Carrier

☐ Claims Experience Attached (Required for Groups of 100+)