



**Proposal Request Form**

Date:

Effective Date:

Contact:			
Company Name:			cell: _____
Street:			Telephone: _____
City, State, Zip:			Facsimile: _____
Total Employee Count:			Current Carrier: _____
SIC#    Industry:			Years in Business: _____

**Census Information**

Employee Name	Employee Birthdate	Employee Gender	Employee Age	Spouse Birthdate	Spouse Gender	Spouse Age	Number of Children
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							
11)							
12)							
13)							
14)							
15)							
16)							
17)							
18)							
19)							
20)							
21)							
22)							
23)							
24)							
25)							

**PLAN DESIGN**

	Current:    Requested:
Deductible: _____	
Coinsurance: _____	
Stop Loss: _____	
Copays: _____	
Other: _____	

**AGENT INFORMATION**

Referred By: _____
Agent:    Terri Cloyd
Agency: American Benefit Consultants
Address: 12137 Rhea Drive, Unit A
Plainfield, IL 60585
Phone:    815-609-6715
Fax:        815-609-9645
email:      tcloyd@abcins.com