Vision Plan of America

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3255 WILSHIRE BOULEVARD ☐ SUITE 1610
LOS ANGELES ☐ CALIFORNIA 90010
FAX ☐ (213) 384-0084

REQUEST FOR PROPOSAL

1. Name of Prospect _____

2. Location _____ **Zip Code** _____

3. Nature of Business _____

4. Are you currently the Broker? _____ **Yes** _____ **No** **Your phone *** _____

5. Print Your Name _____

6. Does your prospect currently have Vision coverage? _____ **Yes** _____ **No**

If Yes:
a. What is/are the current plan(s) (Please Include Benefit Summaries)

Prepaid _____ **Indemnity** _____

b. Current Rates:

Prepaid: _____ **Single** _____ **Couple** _____ **Family**

Indemnity: _____ **Single** _____ **Couple** _____ **Family**

c. Renewal Rates:

Prepaid: _____ **Single** _____ **Couple** _____ **Family**

Indemnity: _____ **Single** _____ **Couple** _____ **Family**

7. Total # of Employees _____ **Total # of Eligible Employees** _____

8. Total # of Participating Employees _____ **(Please Include Census)**

9. What percentage of the Employee Premiums is the Employer Contributing? _____ %

10. What percentage of the Dependent Premiums is the Employer Contributing? _____ %

11. Requested Coverage: **VOLUNTARY** ☐ **EMPLOYER PAID** ☐

Prepaid **Benefit Design; Deductible (if any)** _____

Indemnity **Benefit Design; Deductible (if any)** _____

12. Requested Effective Date _____

13. Broker Signature _____ **Broker Fax #** _____