Group Proposal Request Form

Fax to 231-922-0129 or Email to mstachnik@wrightinsurancegroup.com

Company Name _____

ZIP Code _____

Nature of Business or SIC Code – if known _____

Total # Eligible Employees
(100+ will require 2 years of experience) _____

Current Coverage ☐ **NO** ☐ **YES** If yes, list current carrier and attach copy of current bill and plan design

Agent Name _____

Agent Email Address _____

Plan Requests _____

Effective Date _____

Please complete the below census form or attach a complete census in separate spreadsheet.

	Age or DOB	Gender		Coverage				Dental	Occupation	Salary* (Life, LTD,STD)
1		M	F	EE	ES	EC	EF			
2		M	F	EE	ES	EC	EF			
3		M	F	EE	ES	EC	EF			
4		M	F	EE	ES	EC	EF			
5		M	F	EE	ES	EC	EF			
6		M	F	EE	ES	EC	EF			
7		M	F	EE	ES	EC	EF			
8		M	F	EE	ES	EC	EF			
9		M	F	EE	ES	EC	EF			
10		M	F	EE	ES	EC	EF			
11		M	F	EE	ES	EC	EF			
12		M	F	EE	ES	EC	EF			
13		M	F	EE	ES	EC	EF			
14		M	F	EE	ES	EC	EF			
15		M	F	EE	ES	EC	EF			
16		M	F	EE	ES	EC	EF			
17		M	F	EE	ES	EC	EF			
18		M	F	EE	ES	EC	EF			
19		M	F	EE	ES	EC	EF			
20		M	F	EE	ES	EC	EF			

EE=Employee Only ES=Employee Spouse EC=Employee Children EF=Employee Family

***Please indicate rate of salary (weekly, monthly, annually). Salary not required for Flat Life Amount**