

Group Proposal Request Form

Fax to 231-922-0129 or Email to service@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