

MED PLAN 2000 PROPOSAL REQUEST

Agent Name: _____
 Agency: _____
 California License #: _____
 Employer Name: _____
 Current Medical Plan: _____
 Current Monthly Premium: _____
 Renewal Premium: _____
 Blue Cross \$2000/\$4000 Premium: _____
 Blue Shield \$1650/\$3300 Premium: _____
 Blue Shield \$2250/\$4500 Premium: _____

Please select the following options:

Office Visit	Co-Pay?	Yes _____	No _____	If yes, amount _____
	Co-Ins?	_____	100%/0%	
		_____	90%/10%	
		_____	80%/20%	
		_____	70%/30%	
		_____	60%/40%	
	Deductible?	Yes _____	No _____	If yes, amount \$ _____
RX	Co-Ins?	Yes ____	No ____	If yes, amount _____%
	Co-Pay?	Yes ____	No ____	If yes, amount ____ Generic
				____ Brand

Please call if you would like options that are not listed above or if you have any questions.