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Service of Unequalled Excellence

Proposal Request
(San Diego)

Fax your completed form to 858-643-9297

Broker Information

Broker Name

Agency

Address

City , CA Zip

☐ Check if new address

Broker Code (if known) Broker License #

Phone ( )

Fax ( )

Email Address

Business / Group Information

Company Name

Address

City , CA Zip

1. Nature of Business
2. More Than one Location? ☐ Yes ☐ No
   If yes, where?
3. Number of full-time employees (30+ hours/week)
4. Any employees paid by commission (and/or) paid as independent contractors? (FORM 1099) ☐ Yes ☐ No
5. Any COBRA participants previously employed by you? ☐ Yes ☐ No
   (If yes, indicate on Census located on reverse side)
6. % of costs to be paid by Employer:
   _____ % of Employee costs _____ % of Dependent Costs
7. Type of Employees to be quoted:
   ☐ All ☐ Management ☐ Hourly
   ☐ Salary ☐ Non-Union
8. Employees living Out-of-State? ☐ Yes ☐ No
   (If yes, indicate Zip Code on Census located on reverse side)
9. Desired Effective Date: / /

Proposal Type

- ☐ **Summary Proposal**–Summary of benefits and rates
- ☐ **Custom Proposal**–Details of benefits and rates
- ☐ **California*Choice* Proposal**
- ☐ **Kaiser Permanente Choice Solution**

Products

- ☐ **All**
- ☐ **Medical**
  - ☐ **Blend my census**
- ☐ **Dental**
  - ☐ **Blend my census (custom proposal only)**
- ☐ **Life**
- ☐ **Vision**

Plan Designs

- ☐ **All**
- ☐ **HMO**
- ☐ **PPO**
- ☐ **POS**
- ☐ **Specific Plans (indicate below)**

Specific Plans:

1. _____
2. _____
3. _____

Current Coverage Information

Current Health Plan _____

Current Premium _____

Current Plan Type ☐ HMO ☐ POS ☐ Dual Option ☐ PPO ☐ EPO

RAF Specials

1. Apply RAF Specials Rules ☐
2. Current carrier _____
3. Additional carrier in past 12 months _____
4. Current RAF _____
5. Renewal RAF _____
6. Renewal Date ____ / ____ / ____

Delivery Options

- ☐ Pick-up (check location):
  - ☐ Orange ☐ San Diego ☐ Los Angeles
  - ☐ San Jose ☐ Inland Empire
- ☐ Mail complete proposal
- ☐ Fax to: ( )
- ☐ Email to:
- ☐ Have Representative call me at: ( )

Light Insurance Agency, Inc.5703 Oberlin dr. #301 San Diego, Ca 92121

Fax completed census to 858-643-9297

Company Name: _____ Broker Name: _____

Census

	Name	Medical HMO or PPO	Dental HMO or PPO	Gender	Age or DOB	Spouse (Y/N)	# of Children	COBRA (Y/N)	Home Zip Code	Life Only (Y/N)	Life Amount
1											
2											
3											
4											
5											
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