



American Public Life Insurance Company

A member of the American Fidelity Group

REQUEST FOR PROPOSAL VOLUNTARY GROUP DENTAL

NORMAL PROPOSAL TURNAROUND TIME IS WITHIN FIVE (5) BUSINESS DAYS AFTER RECEIPT.

IF ALL ITEMS WITH AN ASTERISK ARE NOT COMPLETED, A QUOTE CAN NOT BE PROVIDED.

I. BROKER DATA

*AGENT REQUESTING PROPOSAL: _____

*AGENCY: _____

*ADDRESS: _____ *CITY _____ *STATE _____ *ZIP _____

*PHONE _____ FAX _____ E-MAIL _____

PRESENTING AGENT (if different than above) _____

PRESENTING AGENT'S PHONE, FAX, E-MAIL _____

II. EMPLOYER DATA

*EMPLOYER CONTACT: _____

*GROUP NAME: _____

*ADDRESS: _____ *CITY _____ *STATE _____ *ZIP _____

*PHONE _____ FAX _____ E-MAIL _____

***IF MULTIPLE LOCATIONS, LIST EACH LOCATION'S FULL ADDRESS, NATURE OF BUSINESS OR SIC CODE, AND NUMBER OF ELIGIBLE EMPLOYEES PER LOCATION.**

ADDRESS	CITY	STATE	ZIP	NATURE OF BUSINESS OR SIC CODE	# OF ELIGIBLE EMPLOYEES

*NUMBER OF ELIGIBLE EMPLOYEES _____ *EXPECTED PARTICIPATION _____ %

*NATURE OF BUSINESS _____ SIC CODE (If available) _____

*EMPLOYER CONTRIBUTION _____

*DOES GROUP HAVE SECTION 125? YES NO IF YES, SECTION 125 PLAN MONTH _____

III. DENTAL PLAN INFORMATION

*REQUESTED EFFECTIVE DATE _____

*DATE PROPOSAL NEEDED _____

*PROPOSED ENROLLMENT DATES _____

*DOES THE GROUP CURRENTLY HAVE DENTAL COVERAGE? YES NO

*DO YOU REQUEST TO HAVE THE BENEFITS MATCHED? YES NO (If yes, please skip to Payroll Mode question †)

GROUP NAME _____

IV. PLAN REQUESTED

***Please select up to two options. If more than two options are needed, please contact the Group Dental Underwriting Department at 1-800-256-6736 to discuss specific needs for the group.**

“THE AMERICAN SERIES”™

- AMERICAN PREMIERE™
- AMERICAN ENHANCED™
- AMERICAN GRADED™
- AMERICAN CHOICE™ (250+ ELIGIBLE EMPLOYEES)

“THE AMERICAN SCHEDULED PLAN”™

- AMERICAN SCHEDULED BASIC™
- AMERICAN SCHEDULED PLUS™

- 1. AMERICAN PREMIERE™ & AMERICAN ENHANCED™
- 2. AMERICAN PREMIERE™ & AMERICAN GRADED™

	<u>OPTION I</u>	<u>OPTION II</u>
ANNUAL DEDUCTIBLE		
DEDUCTIBLE WAIVED FOR PREVENTIVE		
ANNUAL MAXIMUM		
<i>BENEFIT LEVELS:</i>		
PREVENTIVE		
RADIOGRAPHS – FMX		
BASIC		
BASIC RESTORATIVE		
MAJOR		
ENDODONTICS		
PERIODONTICS		
PROSTHODONTIC REPAIRS		
ORAL SURGERY		
ORTHODONTIC COVERAGE INCLUDED (Yes or No)		
ORTHO LIFETIME MAXIMUM (\$500, \$750, \$1,000, \$1,250 or \$1,500)		
TMJ COVERAGE INCLUDED (Yes or No)		
TMJ MAXIMUM		

✦*PAYROLL MODE: WEEKLY MONTHLY

***TAKEOVER CREDIT REQUESTED? YES NO (IF YES, COMPLETION OF SECTION V IS REQUIRED.)**

GROUP NAME _____

COMPLETION REQUIRED FOR TAKEOVER GROUPS ONLY

V. REQUIRED ITEMS: NO QUOTE WILL BE PROVIDED WITHOUT THIS INFORMATION

- (1) RATE HISTORY
- (2) CLAIMS EXPERIENCE FOR LAST TWO (2) YEARS – MAY INCLUDE CURRENT & PRIOR CARRIER(S)
- (3) CURRENT POLICY OR CERTIFICATE – TO ANALYZE BENEFIT DIFFERENTIALS
- (4) COPY OF CURRENT BILLING

RATE HISTORY:	EE	CHILD	SPOUSE	FAMILY
CURRENT RATES	_____	_____	_____	_____
RENEWAL RATES	_____	_____	_____	_____
PRIOR RATE	_____	_____	_____	_____

If length of time with current carrier is less than 12 months, please list length of time with prior carrier _____

PARTICIPATION: (ATTACH COPY OF CURRENT MONTH'S BILL)

- # ELIGIBLE EMPLOYEES _____
- # ENROLLED ELIGIBLE EMPLOYEES _____
- # ENROLLED DEPENDENTS _____

IF NETWORK INCLUDED IN PRIOR PLAN, PLEASE GIVE NETWORK NAME, DESCRIBE NETWORK, AND ITS DISCOUNT STRUCTURE: _____

GROUP NAME _____

***VII. CENSUS INFORMATION**

(ATTACH ADDITIONAL SHEETS IF NECESSARY, SEND E-MAIL WITH ATTACHMENT, OR ATTACH DISKETTE.)

	AGE/DOB	Male(M)/Female (F)
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	AGE/DOB	Male(M)/Female(F)
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Please send proposal requests to P.O. Box 925, Jackson, MS 39205 or fax to (601) 939-0655. You may contact the Dental Underwriting Department at 1-800-256-6736 or dental@ampublic.com.