



DiBuduo & DeFendis Insurance Brokers
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SMALL GROUP HEALTH INSURANCE PROPOSAL REQUEST

Name of Employer:
Address:

Contact Person: Title:
Phone: () Fax: () E-Mail:
SIC Code or Nature of Business:
D&D Producer Name:
Contribution by Employer to premium is: % of EE Cost % of Dependent Cost
Type of Employer: S Corp C Corp Sole Prop Partnership L.L.P

Requested Effective Date: # of Full Time Employees: # of Employees Covered on Current Plan: Years in Business:

Current Insurance Carrier: Years with Current Carrier:
Renewal Date with Current Carrier: Do They Offer More Than One Plan?
Other Businesses with Common Ownership: Do They Provide Dental, Vision, Life, Other?

Current/Requested Benefit Information: PPO HMO
HSA HRA

If currently insured, please indicate plan name(s) or attach current benefits – if no current coverage, please indicate preferences:

Deductible Range _____ or Metal Tier (circle): Bronze Silver Gold Platinum

Comments/Additional Instructions: