

ATHOS BENEFIT CONSULTING
 (908) 273-2404 / fax (908) 273-1456

PROPOSAL REQUEST

COMPANY NAME
 CONTACT NAME & TELEPHONE
 CONTACT FAX NUMBER
 STREET ADDRESS
 CITY, STATE, ZIP CODE

<input type="checkbox"/> PPO	<input type="checkbox"/> Hosp. Co-pay waiver
<input type="checkbox"/> POS	<input type="checkbox"/> Deductible
<input type="checkbox"/> HMO	<input type="checkbox"/> Co-insurance
<input type="checkbox"/> Rx card	<input type="checkbox"/> Life
<input type="checkbox"/> O.V. Co-pay	<input type="checkbox"/> Dental
<input type="checkbox"/> LTD	<input type="checkbox"/> Vision

CENSUS DATA FOR GROUP INSURANCE

	G E	D.O.B. / AGE	STATUS*	SALARY**	JOB TITLE***	ZIP CODE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

* Employee only: **S** Employee + spouse: **HW** Employee + child(ren): **PC** Family: **F**

** **Required only if** requesting Life Benefits quote

*** **Required only if** requesting Long Term Disability Benefits quote