# PROPOSAL REQUEST FORM

| **Proposal Requested by:** | | **Proposed Effective Date*:** |
|---|---|---|
| Company Name: | Phone Number: | Fax Number: |
| Contact Person: | Contact E-mail Address: | |

**Desired effective date subject to approval by Allegiance COBRA Services.*

| **Company Information** | | |
|---|---|---|
| Company Name: | | Contact Person: |
| Phone Number: | Fax Number: | E-mail Address: |
| Address | | State of Domicile: |
| City | State | Zip Code |
| # Employees: | # Covered Employees: | Average Turnover: % |
| # Current COBRA Participants: | # Locations: | Approximate # of Qualifying Events in Past Year: |

| **Broker Information** | | |
|---|---|---|
| Broker Name: | | |
| Contact Person: | Phone Number: | E-mail Address: |

| **Health Plan Information** | | |
|---|---|---|
| # Medical Plans: | Carrier(s):<br>State situs: | Renewal Date: |
| # Dental Plans: | Carrier(s):<br>State situs | Renewal Date: |
| # Vision Plans: | Carrier(s):<br>State situs: | Renewal Date: |
| Self-funded? ❑ Yes ❑ No | Open Enrollment Date: | |

| **Services Requested** | | |
|---|---|---|
| Initial Notices for new Enrollees?<br>❑ Yes ❑ No | HIPAA Certifications?<br>❑ Yes ❑ No | State Continuation Coverage Admin.<br>❑ Yes ❑ No |