



PROPOSAL REQUEST

Franchise Small Group Trucking Staffing

Broker Information

Name _____

Physical Address _____

City, State, Zip _____

Email Address _____ Phone No. _____

Employer Information

Group Name _____

Physical Address _____

City, State, Zip _____

Contact Name _____ Phone No. _____

Email Address _____

How many locations does this group have? _____

How many eligible participants are in this group? _____

In what state is this group located? _____

Is this group 1099 or W-2? _____

What is the pay range of eligible participants? _____

What is the pay cycle? Monthly 52-Weeks 48-Weeks Bi-Weekly

Will this group be able to provide a census? Yes No

Products Requested

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> TransChoice Plus | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Accident Select | <input type="checkbox"/> TransLegacy Life |
| <input type="checkbox"/> Dental | <input type="checkbox"/> \$4 myPack | <input type="checkbox"/> Accident Advance | <input type="checkbox"/> Group Term Life |
| <input type="checkbox"/> Vision | <input type="checkbox"/> \$6 myPack | <input type="checkbox"/> 401K(i) | <input type="checkbox"/> Critical Illness |
| <input type="checkbox"/> Short-Term Disability | <input type="checkbox"/> \$8 myPack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Universal Life |

Additional Comments
