American Benefit Services

Proposal Request Form

Name of Agent: _____

Agent Phone Number: _____

Agent Email: _____

Name of Group: _____

Group Address: _____

City: _____ **State / Zip:** _____

Type of Industry: _____

Business Entity Type:

❑ Sole Proprietor ❑ C Corp ❑ LLC ❑ Not-for-profit
❑ Partnership ❑ S Corp ❑ Church ❑ Government

Number of Employees: _____

Are all employees in one location: ❑ YES ❑ NO
If not, please list all locations including city, state and zip:

_____
_____
_____
_____
_____

What type of plan are you interested in?

❑ POP ❑ HRA ❑ COBRA
❑ FSA ❑ HSA ❑ SSB
Single Source Billing

Is this a new plan, or an amendment to an existing plan? ❑ NEW ❑ EXISTING

Benefits under this plan will include:

❑ Medical Expenses ❑ Dependent Care Expenses ❑ LLC
❑ Health Premiums ❑ Dental Premiums ❑ Other Premiums

For Other Premiums, please specify:

_____
_____
_____

Please return this form to: **American Benefit Services**
Fax (803) 749-3621