



WBBA
Request for Proposal

Wells Fargo Insurance Services

Group Legal Name:		Nature of Business:		Industry Code:	
Group Address:		City, State:		Zip:	Years in Business:
Requested Effective Date: ___/___/___	Current Renewal Date: Medical: ___/___/___ Dental: ___/___/___	Is group currently a member of the WBBA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long? _____			
Number of Employees:	Medical Contribution (75/0 Minimum) Employee: ___% Dependents: ___%		Dental Contribution (75/0 Minimum) Employee: ___% Dependents: ___%		
Current Benefits – Medical					
Medical Carrier:		How long with this carrier?			
Medical plan design (PPO, POS, CDHP):		Coinsurance:		Preventive Care:	
Deductible: Individual: _____ Family: _____		Out-of-pocket max: Individual: _____ Family: _____			
Office visit copay:	Prescriptions:		Riders:		
Current Benefits – Dental					
Dental Carrier:		How long with this carrier?			
Deductible: Individual ___ Family ___ Waived for P/D? <input type="checkbox"/> Yes <input type="checkbox"/> No		Annual Maximum:		Orthodontia included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coinsurance: Preventive & Diagnostic: ___%		Basic Services: ___%		Major Services: ___%	
Current Benefits – Vision					
Vision Carrier:		Frequency of coverage (Exam/Lens/Frames): <input type="checkbox"/> 12/12/12 <input type="checkbox"/> 12/12/24 <input type="checkbox"/> 24/24/24			
Current Benefits – Vision					
Life/AD&D Carrier:		How long with this carrier?			
Current Rates					
	Medical	Medical	Dental	Vision	
Employee					
EE/Spouse					
EE/Child(ren)					
EE/Family					
Renewal Rates					
	Medical	Medical	Dental	Vision	
Employee					
EE/Spouse					
EE/Child(ren)					
EE/Family					
Submitting WBBA Broker/Agent:		Return this form, an approved Health Risk Questionnaire, and Group Census via email to: Wells Fargo Insurance Services USA, Inc. Attn: WBBA Team Email - wbba.ins@wellsfargo.com Fax – 866.972.4187			
Return quote to:					
Email:					
Fax:					
Phone: ()					