



REQUEST FOR PROPOSAL

Employer Information

Company Name: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Nature of Business: _____ SIC Code: _____
 Phone: _____ Website: _____
 At least 51% Agriculturally Related? Yes No Over 100 Full-Time Equivalent Employees? Yes No
 Seasonal? Yes No High Season (months) _____ High Count: _____ Low Count: _____

Health Coverage Information

Current Carrier: _____ Renewal Date: _____ Rate Increase %: _____
 Waiting Period: Current: () Desired: () Current Enrollment: _____
 Eligible Employees: _____ Ineligible Employees: _____ Requested Effective Date w/ UnitedAg: _____
 Employer Contribution (Current): EE () DEP () Employer Contribution (Desired): EE () DEP ()
 Carve-Out? Yes No Multiple Plans (if allowed): Base/Buy-up Classification Split

Service Representative Information

Service Rep Name: _____ Company: _____
 Phone: _____ DOI License Number: _____

Required Information Included?

Copy of Most Recent Billing: Yes No Copy of Current Benefit Plan: Yes No
 Complete Renewal (if available): Yes No Excel Census (Large, Small, Seasonal) Yes No

Health Questionnaire (Large Employers Only)

- Is any person to be covered unable to work due to injury or illness? Yes No
- Is any person currently hospitalized or pending future extensive medical treatment, surgery or hospitalization? Yes No
- Is any person being treated for heart disease, stroke, cancer, kidney disorder, AIDS, AIDS related complex, Chronic Respiratory Disease or any other serious condition? Yes No
- Has any person suffered a condition which resulted in expenses of \$25,000 or more or been hospitalized in the last 12 months? Yes No
- Do you currently have COBRA applicants? Please indicate date of qualifying event and reason on detail below. Yes No

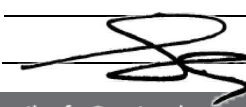
Please provide detail for all questions marked "Yes" in the area provided below

Employer & Service Representative Certification

- I understand that participation in the United Agricultural Benefit Trust is only available to active members of United Agribusiness League. Based upon my approval of a health benefit plan from UABT, I (the employer) am willing to become a Member of the League.
- The undersigned also hereby acknowledges that to the best of their knowledge and belief, all of the responses given above are true, correct, and complete. Once this group is accepted, this document becomes part of the Group Application. UABT may, at its sole option, adjust the rates retroactively if misstatements are made. UABT reserves the right to change rating (where applicable) if final enrollment fluctuates.

Authorized Signature (Employer): _____ Date: _____

Print Name: _____ Job Title: _____

Appointed Service Rep. Signature (Regarding Certification #2 Only):  _____ Date: _____