unitedag | 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: Gardner Cook **Company:** Cook Insurance Brokers

Phone: 707-935-7362 **DOI License Number:** 0814071

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)*

1. Is any person to be covered unable to work due to injury or illness? **Yes ❑ No ■**
2. Is any person currently hospitalized or pending future extensive medical treatment, surgery or hospitalization? **Yes ❑ No ■**
3. 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 ■**
4. 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 ■**
5. 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

1. 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.
2. 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:** _____