M-D UNDERWRITING SERVICES, INC.

QUOTATION REQUEST Date Quote Needed_______________

NAME OF PROSPECT____ Proposed Effective Date______________

Nature of Business____ Years in Business___________________

Address____

List other locations or subsidiaries including the # of employees and zip code of each:

Name and Address	Zip Code	# of Employees

FIRM REQUESTING QUOTE____

Address____

Person to Contact Phone # (________)________-___________

SPECIFIC COVERAGE ______ Yes ______ No Deductibles Desired: *

Contract Basis Desired:

______ 12/12	______ 14/12	$ _________________
______ 12/15	______ 15/12	$ _________________
______ 12/24	______ 24/12	$ _________________

* $15,000 minimum

AGGREGATE COVERAGE____ Yes ______ No Benefits To Be Covered:

Contract Basis Desired:

		______ Medical	______ Vision
______ 12/12	______ Paid (Renewal Only)	______ Dental	______ PDC
______ 12/15	______ 15/12	______ WDI	______ Other

SPECIAL REQUESTS____

____

____

____

____

SELF INSURED EXPERIENCE

Most Recent Period _____/____/_____ To _____/____/_____

Claims Administrator ____________________ Excess Loss Carrier ________________

Specific Deductible ________________ Aggregate Premium ________________
Specific Rates ________________ Aggregate Factors ________________

Contract Basis ________________ Contract Basis ________________

	Month	#Single Employees	#Family Employees	Total Paid Claims		Month	#Single Employees	#Family Employees	Total Pd Claims
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

Second Period _____/____/_____ To _____/____/_____

Claims Administrator ____________________ Excess Loss Carrier ________________

Specific Deductible ________________ Aggregate Premium ________________
Specific Rates ________________ Aggregate Factors ________________

Contract Basis ________________ Contract Basis ________________

	Month	#Single Employees	#Family Employees	Total Paid Claims		Month	#Single Employees	#Family Employees	Total Pd Claims
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

Third Period _____/____/_____ To _____/____/_____

Claims Administrator ____________________ Excess Loss Carrier ________________

Specific Deductible ________________ Aggregate Premium ________________
Specific Rates ________________ Aggregate Factors ________________

Contract Basis ________________ Contract Basis ________________

	Month	#Single Employees	#Family Employees	Total Paid Claims		Month	#Single Employees	#Family Employees	Total Pd Claims
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

FULLY INSURED EXPERIENCE

Most Recent Period ____/____/____ To ____/____/____

Carrier ____

Coverage	Paid Premiums	Paid Claims	Single Rates	Family Rates	Average # EE's	Average # EE's with Dep
Medical						
Dental						
A & S						
RX Drugs						
Other						

Second Period ____/____/____ To ____/____/____

Carrier ____

Coverage	Paid Premiums	Paid Claims	Single Rates	Family Rates	Average # EE's	Average # EE's with Dep
Medical						
Dental						
A & S						
RX Drugs						
Other						

Third Period ____/____/____ To ____/____/____

Carrier ____

Coverage	Paid Premiums	Paid Claims	Single Rates	Family Rates	Average # EE's	Average # EE's with Dep
Medical						
Dental						
A & S						
RX Drugs						
Other						

RENEWAL RATES

Please provide renewal rates from the current carrier (self-insured or fully insured) for the proposed effective date. **If the prospect is both fully insured and less than 100 lives, renewal rates are required before a quotation will be provided. (please circle the appropriate heading)**

Single or Employee $ ____________ 2 Person $ ____________ Dependent or Family $ ____________

EMPLOYEE BENEFIT PLAN

Please attach a copy of the Employee Benefit Plan in effect during each of the experience periods. List any benefit changes over the past three years, including the dates implemented, or any new changes expected to be made to the current plan of benefits for the upcoming coverage period.

ENROLLMENT INFORMATION

Please attach a census with the date of birth, sex and dependent status for all plan participants. Please be sure to include all COBRA participants as well as potential COBRA beneficiaries. If retirees are to be covered, they must be clearly identified on the census. An indication of employees participating in other medical benefit programs, such as H.M.O.s and P.P.O.s, must also be made.

Contribution Status:	Employees	Dependents
	______ Contributory _______ %	______ Contributory _______ %
	______ Non-Contributory	______ Non-Contributory

LARGE CLAIM INFORMATION

Provide Requested Details on the following persons:

1. **Any currently disabled employee, dependent, COBRA participant or retiree;**
2. **Any claim in excess of 50% of the lowest Specific Deductible requested for the last three years;**
3. **Any ongoing claim of a serious nature.**

Name ______________________________ Total Claims Received-To-Date ______________

Employee or Dependent Age _____ Sex M or F Date Last Claim Received ______________

Diagnosis ______________________________ Date of Onset ______________

Prognosis ______________________________ Claimant is _____ Active

__________Terminated

______________________________________ _____ Retired _____ On Cobra

Name ______________________________ Total Claims Received-To-Date ______________

Employee or Dependent Age _____ Sex M or F Date Last Claim Received ______________

Diagnosis ______________________________ Date of Onset ______________

Prognosis ______________________________ Claimant is _____ Active

__________Terminated

______________________________________ _____ Retired _____ On Cobra

***NOTE: Additional Large Claim information MUST be listed on page 5.**

I/We hereby declare that the preceding statements and particulars are true and I/We have not knowingly suppressed, withheld or misstated any material facts hereon and agree that this information shall be the basis upon which the proposal is issued.

Signed by ____ Date ____________________

ADDITIONAL LARGE CLAIM INFORMATION

Name ______________________________ Total Claims Received-To-Date ____________
Employee or Dependent Age _____ Sex M or F Date Last Claim Received ____________
Diagnosis ______________________________ Date of Onset ____________
Prognosis ______________________________ Claimant is _____ Active
__________Terminated
______________________________ _____ Retired _____ On Cobra

Name ______________________________ Total Claims Received-To-Date ____________
Employee or Dependent Age _____ Sex M or F Date Last Claim Received ____________
Diagnosis ______________________________ Date of Onset ____________
Prognosis ______________________________ Claimant is _____ Active
__________Terminated
______________________________ _____ Retired _____ On Cobra

Name ______________________________ Total Claims Received-To-Date ____________
Employee or Dependent Age _____ Sex M or F Date Last Claim Received ____________
Diagnosis ______________________________ Date of Onset ____________
Prognosis ______________________________ Claimant is _____ Active
__________Terminated
______________________________ _____ Retired _____ On Cobra

Name ______________________________ Total Claims Received-To-Date ____________
Employee or Dependent Age _____ Sex M or F Date Last Claim Received ____________
Diagnosis ______________________________ Date of Onset ____________
Prognosis ______________________________ Claimant is _____ Active
__________Terminated
______________________________ _____ Retired _____ On Cobra

Name ______________________________ Total Claims Received-To-Date ____________
Employee or Dependent Age _____ Sex M or F Date Last Claim Received ____________
Diagnosis ______________________________ Date of Onset ____________
Prognosis ______________________________ Claimant is _____ Active
__________Terminated
______________________________ _____ Retired _____ On Cobra