REQUEST FOR PROPOSAL
6/25/05

LANG FINANCIAL GROUP, INC.
4225 Malsbary Rd, Ste. 100, Cincinnati, OH 45242

COMPANY:

ADDRESS:

INDUSTRY/SIC CODE:

PROPOSED EFFECTIVE DATE: **PROPOSAL DEADLINE:**

SUBJECT TO COBRA: **CURRENT COBRA PARTICIPANTS:**

HEALTH CONDITIONS KNOWN:

COVERAGE(S) TO QUOTE:	*Employer Contribution: Employee/Family*	*Current Carrier:*	*Effective Date:*
MEDICAL:			
LIFE:			
DENTAL:			
LONG TERM DISABILITY:			
SHORT TERM DISABILITY:			

CURRENT RATES:	*Medical*	*Dental*	*Life/AD&D*	*LTD*	*STD*
Employee:					
Employee/Spouse:					
Employee/Children:					
Family:					

RENEWAL RATES:	*Medical*	*Dental*	*Life/AD&D*	*LTD*	*STD*
Employee:					
Employee/Spouse:					
Employee/Children:					
Family:					

CURRENT BENEFITS:

MEDICAL:
LIFE:
DENTAL:
LONG TERM DISABILITY:
SHORT TERM DISABILITY:

BENEFITS TO BE QUOTED:

MEDICAL:
LIFE:
DENTAL:
LONG TERM DISABILITY:
SHORT TERM DISABILITY:

NOTES:

CURRENT AGENT: YES NO

PRODUCER: Mike Roehm (513) 699-2974/fax 699-2975
PRODUCER: Brett Seip (513) 699-2980/fax 699-2981
PRODUCER: Alan Zeff (513) 699-2984/fax 699-2985

ADMIN. ASST: Ellen Langford (513) 699-2962/fax 699-2963
ADMIN. ASST: Belinda Keeble (513)699-2958/fax 699-2959
ADMIN. ASST: Joy Farrell (513) 699-2950/fax 699-2951

GROUP RISK EVALUATION QUESTIONNAIRE

Company Name:_________________________________ Telephone # ______________Fax #_____________

Address:____City_______________________State_________Zip_____

Nature of Business ____ SIC Code, if known: _______________

Are any affiliates or subsidiaries to be included? ________ If yes, please give complete name(s) and addresses of same:

____

Total Employees on Payroll (including part-time, seasonal, etc): ____________ # of Eligible Employees: _______

# of Eligible Employees Electing Coverage: ____________ # of Retired Employees Electing Coverage:________

# of COBRA Participants _______ Please complete the chart below (use separate sheet, if necessary):

Participant's Name	Is Part. EE, EE's Spouse or EE's Child?	D.O.B.	Event (Termination, Divorce, etc.)	COBRA Termination Date	Coverage Election (EE, EE/Sp, EE/Ch, FAM)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Are there any employees, dependents, or COBRA beneficiaries with scheduled hospitalization or surgery pending (including maternity)? If yes, please explain:____

____

Is any employee not actively at work or expected to be not actively at work on the effective date due to disability? _
If yes, please give details: ____

Is any dependent or COBRA beneficiary known to be disabled, receiving Social security disability payments, or covered on Medicare due to disability? If yes, please give details: ____

____

Have there been any employees, dependents, or COBRA beneficiaries with claims of $5,000 or more in the last 12 months? If yes, please explain: ____

____

Are there any employees, dependents, or COBRA beneficiaries with any of the following health conditions? If yes, please check and if more than one of the same conditions exist, please indicate the number:

______	Aids	______	Emphysema	_____	Paralysis
______	Arthritis	______	Epilepsy	_____	Pericarditis
______	Cancer (under treatment)	______	Kidney	_____	Pregnancy (Due Date?)
______	Cancer (treated in past 5 yrs)	______	Kidney Dialysis	_____	Premature Infant Syndrome
______	Cancer (not treated in 5 yrs)	______	Liver (Cirrhosis)	_____	Renal Failure
______	Cerebral Palsy	______	Liver (Hepatitis)	_____	Spinal Deformity
______	Congenital Defects	______	Lupus	_____	Stroke
______	Coronary/Heart Disease	______	Marfan Syndrome	_____	Surgery Pending
______	Cystic Fibrosis	______	Mental Disorders	_____	Transplants
______	Diabetes	______	MS or MD	_____	Tuberculosis
______	Drug/Alcohol Abuse	______	Organ Tissue Transplant	_____	Other __________________

Please provide details to all indicated conditions above, if known (use separate sheet, if necessary): _____________

____

I hereby certify that the above information is true to the best of my knowledge and belief.

___________________________	___________________________	___________________________
Signature	Date	Lang Financial Group, Inc.

THE DISCLOSED INFORMATION IN THIS DOCUMENT MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL, AGENT'S WORK PRODUCT AND/OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. INFORMATION DISCLOSED IN THIS DOCUMENT IS INTENDED FOR THE USE OF LANG FINANCIAL GROUP, INC., ITS AFFILIATES, AND OTHER HEALTH INSURANCE COMPANIES THAT LANG FINANCIAL GROUP IS LICENSED WITH. THIS INFORMATION WILL REMAIN CONFIDENTIAL AND ONLY BE USED FOR THE PURPOSE OF UNDERWRITING.

EMPLOYEE CENSUS DATA Company Name ____________________

	Employee Name	Sex		EE DOB	Spouse DOB* If available	Job Title	Earnings ** (indicate per Hr, Wk, Mo, Yr)	Medical Coverage				Dental Coverage				# of Children Covered	Waiver	Not Elig	EE Location City, Cty, St, Zip (if outside Greater Cinti)
		Female	Male					EE Single	EE/Sp EE/Spouse	EE/Ch EE/Children	Fam Family	EE Single	EE/Sp EE/Spouse	EE/Ch EE/Children	Fam Family		Life Only	New, PT, Temp	
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* Spouse DOB, if available, when spouse is insured, may affect premium rate; otherwise, spouse assumed same age as employee.
** Salary information may be necessary to calculate wage-based life and disability insurance coverages.

For assistance in completing this form, please call:

LANG FINANCIAL GROUP, INC.
4225 Malsbary Road, Suite 100, Cincinnati, OH 45242
Phone 513-984-3100 or 800-288-3105 Fax 513-984-4634

ALL DATA SUBMITTED IS KEPT STRICTLY CONFIDENTIAL