Proposal Request Form

Broker Name: ______________________ **Date** (mm/dd/yyyy): ______________

E-mail: ______________________ **Phone Number:** ______________

Submit Quote: In person ❑ E-mail ❑ Mail ❑

Complete this form, save it, and send to: *quotes@cecvision.com.*

GROUP INFO

Group Name: ______________________

Group Address: ______________________

City ______________ **County** ______________ **State** ______________

List multiple locations: ______________________

Number of Employees: __________ **Any Employees in Other States:** Yes ❑ No ❑

FUNDING

❑ **Voluntary (employee-paid)**

❑ **Employer-Paid**

❑ **Other (specify)** ______________________

CURRENT COVERAGE

Does group currently have a vision plan: Yes ❑ No ❑ *(If Yes, please complete the following:)*

Who is the incumbent vision vendor: ______________________

What are the co-pays: exam $ ______ eyewear $ ______

What are the allowances: frames $ ______ contact lenses $ ______

What is the plan frequency: Exam .... 12 month ❑...... 24 month ❑

Frames ...... 12 month ❑...... 24 month ❑

Lenses .... 12 month ❑...... 24 month ❑

Current Rates: $__________ $__________ $__________ $__________

Rate Interval (monthly, bi-weekly, semi-monthly or weekly): ______________________

PROPOSED PLAN

Effective Date Desired (mm/dd/yyyy): ____________

Proposed Vision Plan Design: Exam & Eyewear ❑ Eyewear Only ❑

Rate Structure Requested: 2-tier ❑ 3-tier ❑ 4-tier ❑

Rate Interval: Monthly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Weekly ❑

Requested co-pays: exam $ ______ eyewear $ ______ contact lens fitting $ ______

Requested allowance: $ ______________

Specific Requests: ______________________