American Insurnet **Worksite GAP Plan Request**

ILLUSTRATION REQUEST FORM

FAX TO AMERICAN INSURNET 513-287-7777

AGENT NAME
PHONE ( ) -
FAX ( ) -
EMAIL

ADDRESS

COMPANY NAME:
STATE OF DOMICILE:
SIC CODE:
CONTACT:

ADDRESS

CURRENT HEALTH PLAN INFORMATION:

PRESENT CARRIER ______________________ **RENEWAL DATE** ____________

	# OF UNITS	CURRENT RATE	RENEWAL RATE	PROPOSED RATE
Single EE's		$	$	$
EE's & SPOUSE		$	$	$
EE's & CHILDREN		$	$	$
FAMILY		$	$	$

	CURRENT IN NETWORK	CURRENT OUT OF NETWORK	PROPOSED IN NETWORK	PROPOSED OUT OF NETWORK
DEDUCTIBLE				
CO-INSURANCE				
OUT OF POCKET MAX.				
OFFICE VISIT CO-PAY				
EMERGENCY ROOM DEDUCTIBLE				
PRESCRIPTION DRUG CARD				
PLAN LIFETIME MAX.				

PLEASE LIST ALL MAJOR EMPLOYEE HEALTH ISSUES IN THIS GROUP: