



INSURANCE PLANNING & SERVICE COMPANY, LLC

- Proudly Serving Tennessee Physicians for 50 Years -

GROUP HEALTH PROPOSAL REQUEST FORM

Practice Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Primary Contact: _____

Phone: _____ Fax: _____

Email: _____

Type of Business: _____ Group Tax ID: _____

Total # of Employees: _____ # of Full Time Employees: _____ # of Employees Participating: _____

Please complete each blank for all full time employees and their participating dependents. For any full time employees that do not wish to participate write "W" in the tier column.

Table with 8 columns: Last Name, First Name, Home Zip Code, Gender (M or F), Date of Birth (MM/DD/YYYY), Tobacco (Y or N), Relation (See Below), Tier (See Below). The table contains 15 empty rows for data entry.

Relation: Emp = Employee Sp = Spouse Ch = Child

Tier: EE = Employee Only ES = Employee + Spouse EC = Employee + Child(ren) F = Family W = Waive

If additional lines are needed, please send in Excel format. Be sure to include all of the requested information listed above.

Submit Completed Forms to:

IPSCO | 6505 Lee Highway, Chattanooga, TN 37421

P: 800.347.1109 | F: 866.791.2806 | info@ipscophysicians.com | ipscophysicians.com