American College of Surgeons
INSURANCE PROGRAM
PO BOX 153054 • IRVING TX 75015-3054

Employer Group Proposal Request

Member Name:	ACS Member Number:	
Address:		
City:		
State: Zip:	County:	
Telephone:	Fax#:	
Contact Person:	# of Employees in Group:	# of Employees to be covered:

QUESTIONS?
Call us toll-free at 1.800.433.1672

Please Fax to: 469-417-1675
Attn: Sheila Harrison
or mail to: ACS Insurance Program
P.O.Box 153054
Irving, TX 75015-3054

Employees out of state (name, city, state, zip):

Coverages Requested:

Effective Date Needed: _____

- ☐ MAJOR MEDICAL
- ☐ MATERNITY
- ☐ LIFE INSURANCE Amount: _____
- ☐ LONG TERM DISABILITY
- ☐ SHORT TERM DISABILITY
- ☐ INTEGRATED TERM DISABILITY
- ☐ DENTAL With Ortho? ☐ Yes ☐ No

Current Coverage Details

Current Carrier: _____
Current Monthly Premium: _____
Renewal Date: _____
Deductible: _____
Co-Insurance: _____
Co-Pay: _____
Portion Employer will pay toward Premium:
_____ employee/ _____dependents
Any known health conditions _____
_____
Special Request: _____
_____

COMPLETE THE SECTION BELOW FOR ALL EMPLOYEES (Please make copies or use additional paper if needed.)

Employee's Name Last	First	Sex	Date of birth/Age Employee	Spouse	Tobacco Use (Y/N) Employee	Spouse	# of Children	Gross Annual Salary (For Disability Only)	Occupation	Residential Zip Code

NOTE: The premium rates used to calculate your proposal will be the carrier's preferred risk rates. Actual premiums charged may vary depending upon the existence of certain factors that deviate from standard cost of services. The factors, together called "the risk adjustment factor," include , but are not limited to, medical history, type of industry, and turnover. (Coverages may not necailable in all states.