



**Claims Administrative Services, Inc.**  
 P.O. Box 7500 • Tyler, Texas 75711  
 (903) 509-8484 • (800) 765-2412 • Fax (903) 509-1888  
 www.cas-services.com • Attention: Bob Mitchell, MHP

# CASFlex

## Data Request Form

For which products would you like to receive a proposal? *(Please check all that apply)*

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Accident   | <input type="checkbox"/> AD&D           | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Dental            |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Heart/Stroke   | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Medical Gap Plans |
| <input type="checkbox"/> Term Life  | <input type="checkbox"/> Universal Life | <input type="checkbox"/> Vision         | <input type="checkbox"/> Whole Life        |

Name of Employer:	Industry S.I.C. Code:		
Street Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Contact Name:	County:		
Phone:	Fax:	Email:	
Current Agent/Broker/Consultant:	Phone:		

Approximate number of employees working 30 or more hours:

Do you cover part-time employees <30 hours per week?  Yes  No

Do you cover retirees?  Yes  No

Total number of employees currently covered under your Health Plan:

Of those employees covered, how many have:      Single Coverage \_\_\_\_\_      Dependent/Family Coverage \_\_\_\_\_

Total number of employees covered under your voluntary plan *(if any)*:

Name of Current Carrier/TPA:	How Long?	Renewal Date:
Current Voluntary Rates:	Renewal Rates:	
<i>(Attach copy of current billing)</i>		
Is your Voluntary Plan currently included in your Cafeteria/Section 125 plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anniversary Date
<i>(Attach copy of Voluntary Plan Schedule of Benefits)</i>		of Cafeteria Plan: _____

- Underwriting Requirements: *(please include information below as an attachment)*
- a) Completion of this Data Request Form
  - b) Full Census *(includes: employee name, sex, DOB (m/d/y), job title, monthly (or annual) salary, dependent coverage status (employee only, employee & spouse, employee & child(ren), employee & family), current voluntary life amount, current disability income benefits)*
  - c) 24 months claims experience
  - d) any on-going disability claims or death claims *(please include diagnosis/prognosis & amount of claims paid)*
  - e) current benefits information *(copy of schedule of benefits)*
  - f) COBRA participants & types of voluntary coverage *(including census for COBRA employees)*
  - g) does plan require use of PPO?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Employer Representative

**IF YOU SHOULD HAVE ANY QUESTIONS IN COMPLETING THIS FORM, PLEASE DO NOT HESITATE TO CONTACT BOB MITCHELL AT (800) 765-2412, EXT. 217 OR FAX 903-509-1888.**

BY YOUR SIGNATURE YOU HEREBY AGREE THAT ALL MATERIAL IN THE PROPOSAL WHICH YOU WILL RECEIVE AND ALL OTHER FUTURE INFORMATION AND DOCUMENTS IN CONNECTION WITH THIS PLAN ARE PROPRIETARY AND CONFIDENTIAL. SUCH INFORMATION AND DOCUMENTS ARE ONLY TO BE USED IN THE EVALUATION OF CLAIMS ADMINISTRATIVE SERVICES, INC. CONCEPTS AND PRODUCTS. NO COPIES ARE TO BE PROVIDED TO ANY THIRD PARTIES WITHOUT THE CONSENT OF CLAIMS ADMINISTRATIVE SERVICES, INC.