ADVANCE INSURANCE COMPANY OF KANSAS
REQUEST FOR PROPOSAL

Prospect Name:			
Address:			
City, State, Zip			
Nature of Business:			
Class Description:			

Contributory:	**Yes**		**No**		**If Yes, Participation Level:**	

Date Sent:		**Date Needed:**		**Effective Date:**	
Underwriter:		**BCBS Rep:**			
		Broker:			

Proposal Data	**Standard Options**	**Inforce Plan**	**Option I**	**Option II**
Benefit Percent	50% 60% 66 2/3% **Non-Contrib Only**			
Maximum Mo. Benefit	6,000			
Minimum Mo. Benefit	$100 / 10%			
Elimination Period	90 Days 180 Days			
Benefit Duration	ADEA 1			
Integration	Direct Family			
Def. of Disability	24 Months			
Partial/Residual	Residual			
Rate Guarantee	24 Months			
Pre-Existing Limit	12/12/24 (<25 lives) 3/12 (25 lives)			
Survivor Benefit	3 Months			
Mental Nervous	24 Months Lifetime			
Drug & Alcohol	24 Months			

Inforce LTD Carrier:					
Inforce Rate:		Renewal Rate:		# of Employees:	
Additional Notes:					

For all quotes, please supply the following census data:
a.) Age or Date of Birth b.) Gender c.) Salary (with identifier) d.) Occupation (specialty, if physician)

For all cases with a prior carrier (300 lives or greater), please supply the following:

1. Copy of present Booklet, Certificate, or Contract
2. Rates, Paid Premium, and Paid Claims for at least the past 3 years*
3. List all open claims showing:
   a.) Date of Disability b.) Date of Birth c.) Date of Recovery d.) Gross Monthly Benefit
   e.) Occupation f.) Gender g.) Diagnosis h.) Social Security Offset (if applicable)

*Please try to obtain for all case sizes.