GRIMALDI INSURANCE

ESTABLISHED 1910

REQUEST FOR PROPOSAL

COMPANY NAME **DATE**

ADDRESS **CITY** **STATE** **ZIP**

CONTACT PERSON **PHONE** **FAX**

FEDERAL I.D. #______________________ **STATE UCT #**______________________

SOLE PROP. _____ **CORPORATION** _____ **PARTNERSHIP** _____ **LLC** ______ **YEARS IN BUSINESS** ______

PAY PERIOD:__________ **CUTOFF:**__________ **DELIVERY:** __________ **PAYDAY:**__________

BRIEF DESCRIPTION OF THE OPERATION:

WORKMAN'S COMPENSATION INFORMATION IS AS FOLLOWS:

JOB DESCRIPTION	W/C CODE	NO. Of EE'S	PAYROLL AMOUNT

ADDITIONAL INFORMATION DESIRED IN FOLLOWING AREAS: (Check all which apply)

HEALTH INSURANCE **% PAID BY EMPLOYER** **401K** **LIFE INS** **DISABILITY**

HIRE & RETENTION **EPLI** **DENTAL** **VISION** **HANDBOOK** **SAFETY TRAINING**

COMMENTS: