DPC|Core

RFP Request Form

Broker Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Email: _____

Brokerage Name: _____

Agent Name: _____

Pay commission to: _____

Client Information

Complete form for DPC Core. This form is required to for each client referred.

RFP Request Due Date _____

Client Enrollment Effective Date _____

Employer Membership Allowance type – Select one

_____ Employee Only — Dependents voluntarily deducted from payroll

_____ Employee + Dependents — Company pays for employee and eligible dependents

Commission Structure

☐ Set Fee ☐ Percentage ☐ No Commission

Fee Amount: _____ Percentage: _____

List the Retail Price for Each Membership Tier

*Individual + 1 and Family Membership Rates apply only if the same clinic is selected

Individual	*Individual + 1	*Family

Major Medical Plan Type Offered			
PPO	HDHP	Level Funded	Self-Funded

Please include the below information when submitting this request to DPC Core.

- Employee Census Information – Include Zip Codes
- Historic Utilization Data – If available

Fax or Email this form and requested information to:

Email:Secure@DPCCore.com

Fax: 360.838.1081

Agent Signature Date

DPC Core Use Only

Date Received	Received By:
Process Date	Date Request Sent
Processed by:	Sent by: