



GROUP HEALTH QUOTE REQUEST FORM

ACCOUNT NAME: _____

TYPE OF BUSINESS: _____ DATE: _____ AGENT NAME: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP CODE: _____

EFFECTIVE DATE: _____

QUOTED CARRIERS WILL BE BASED UPON BEST SELECTION PER YOUR CLIENT'S PROFILE

PLAN REQUESTED: PPO: 90/70 or 80/60 QUOTE HSA: [] yes [] no QUOTE HRA: [] yes [] no QUOTE HMO: [] yes [] no

DEDUCTIBLE: [] \$250 [] \$500 [] \$1,000 [] \$1,500 [] \$2,000 OTHER _____

STOP LOSS: [] \$2,500 [] \$5,000 [] \$10,000 or indicate out of pocket \$ _____

OPTIONAL BENEFITS

[] Supplemental accident: (\$300 or \$500 ER deductible) Maternity: [] yes [] no Rx card: [] yes [] no

Wellness: [] yes [] no Life amount \$ _____

Dependent Life: [] yes [] no (Spouse - \$5,000 or \$2,500 / Child - \$2,500 or \$1,000)

Long term disability: [] yes [] no (If yes, indicate the elimination period): [] 90 or [] 180 days

Please indicate duration: [] 2yrs/RBD [] 5yrs/RBD [] to age 65/RBD

Short term disability: [] yes [] no (If yes, indicate if flat amount or by % of salary _____)

[] 13 weeks [] 26 weeks

Dental: [] yes [] no (If yes, indicate calendar year maximum) [] \$500 [] \$1,000 [] \$1,500

Orthodontia coverage: [] yes [] no (does the group have prior dental coverage? _____)

Current Carrier: _____ How long? _____ Current premium? _____

PLEASE NOTE THAT IN ORDER TO GET A PRE-SCREENED QUOTE FROM OUR OFFICE, YOU MUST PROVIDE COMPLETED EMPLOYEE APPLICATIONS. CALL OUR OFFICE FIRST TO GET DETAILS ON WHAT THE CARRIER'S REQUIREMENTS ARE.

Your email address: _____ (We are able to email most carriers quotes. We also try to send updates and important information by email.) Your fax number: _____

Should we: [] e-mail quotes to you [] fax quotes to you [] mail quotes to you

Fax both pages to: 317-841-5070

Employee Census Information

	Employee Age or Date of Birth	Sex M/F	Coverage	Spouse's Age or Date of Birth	Number Of Children	Annual Salary (For disability purposes)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

Coverage Codes:

E = Employee only EC = Employee & Child ES = Employee & Spouse F= Family LO = Life Only

**FAX BOTH PAGES TO
317-841-5070**

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