Group Medical Quote Request

Group Name: _____

Industry: _____

Business Type: ❑ C-Corp ❑ S-Corp ❑ LLC ❑ Other: _____

FEIN: _____

Address: _____

Phone #: _____

Group Contact & Title: _____

Current Provider: _____

# of Years with Current Provider: _____

# of Eligible Employees: _____

# of Employees Currently Enrolled: _____

# of COBRA Participants: _____

Employee Pay Frequency: ❑ Weekly ❑ Bi-Weekly (26 Periods) ❑ Semi-Monthly (24 Periods) ❑ Monthly

Current Coverage (Check all that apply):

❑ Medical	❑ Basic Group Term Life	❑ Supplemental (i.e. Aflac)
❑ Dental	❑ Short/Long Term Disability	
❑ Vision	❑ Voluntary Life/AD&D	

Employer Contribution:

Employee: _____ Dependents: _____

In order to quote, we will need the following documentation:

- Current Plan Design and Rates
- Renewal Plan Design and Rates
- Census with all Eligible Employees & Covered Dependents Including:
    - DOB
    - Gender
    - Zip Code
    - Current Enrollment
    - Coverage Tier (EE,ES,EC,F)
    - Any available Claims Reporting