



DATE/TIME:

REFERRED BY:

BUSINESS PROFILE: HEALTH INSURANCE QUOTE REQUEST

Business Information:

BUSINESS NAME

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

CURRENT NUMBER OF FULL TIME EMPLOYEES

CURRENT NUMBER OF PART TIME EMPLOYEES

MAILING ADDRESS:

ADDRESS

CITY, STATE

ZIP

NATURE OF BUSINESS

TAX ID # / EIN #

Current Benefits:

DO YOU CURRENTLY OFFER BENEFITS?

EMPLOYEES ENROLLED

EMPLOYEES WAIVED

CURRENT INSURANCE COMPANY:

REQUESTED EFFECTIVE DATE:

Preferred Benefit Design:

BENEFIT(S) TO INCLUDE IN PLAN:	EMPLOYER CONTRIBUTION?
<input type="checkbox"/> MEDICAL	<input type="text"/>
<input type="checkbox"/> DENTAL	<input type="text"/>
<input type="checkbox"/> VISION	<input type="text"/>
<input type="checkbox"/> LIFE INSURANCE	<input type="text"/>
<input type="checkbox"/> LONG TERM CARE	<input type="text"/>
<input type="checkbox"/> LONG TERM DISABILITY	<input type="text"/>

**Minimum required is 50% of the EE Medical portion. All other benefits can be elected to be offered at 100% cost to the employee (Voluntary).*

The employer can choose to pay as much as they want above the required 50% minimum as an added benefit to their employees.

ADDITIONAL NOTES:

Please complete the Employee Information Table on the back of this form.

In order to provide the best apples to apples comparison to your current coverage, if any, we ask that you provide us your most recent renewal packet including plan design and premium information.

