



# Large Group Quote Request

## HEALTH PLAN

Date: \_\_\_\_\_

Name of Contact:	Phone:
Agency Name:	Phone:
Agent Name:	Email Address:

Company Name:		
Address:		
City:	State:	Zip:
Type of Business:		

Current Carrier:	
Renewal Date of Current Plan:	Effective Date Requested:

Current Rates	
Single	\$ _____
Double	\$ _____
Family	\$ _____

Renewal Rates	
Single	\$ _____
Double	\$ _____
Family	\$ _____

How many plans are offered:	
Plan 1: _____	# enrolled: _____
Plan 2: _____	# enrolled: _____
Plan 3: _____	# enrolled: _____
Plan 4: _____	# enrolled: _____

Covering Pre-65 Retirees?
Covering Post-65 Retirees?

Total Number of Full Time Equivalents:
Total Number of Eligible Employees:
Total Number of Enrolled Employees:

Is the group wrapping any part of the deductible, coinsurance or copayments? _____ Yes _____ No
Claims received: _____ Yes _____ No
Claims requested: _____ Yes _____ No
# OOS/OOA: _____

Please send us a copy of your current benefit plan summary page along with the completed census form (**including zip codes**).

If you have any questions, please call our Sales team at 888-327-0671.