TODAY'S DATE ________________ REFFERED BY: _________________________

PROPOSED EFFECTIVE DATE____

COMPANY NAME ___________________________ DBA ________________________

CONTACT ______________________________ PHONE 1________________________

ADDRESS ______________________________ PHONE 2 ________________________

_______________________________________ FAX ___________________________

EMAIL ___________________________ WEBSITE _________________________ ____

ADDITIONAL LOCATIONS ____

NATURE OF BUSINESS ___________________________ SIC/ NAIC'S ____________

QUOTE FOR:

____ **MEDICAL**-*DEDUCTIBLES* ________________ *COINSURANCE* ________________

____ HMO ____ PPO _____ HSA _____INDEMNITY ____ MATERNITY

____DRUG CARD ____ COPAY ______________

____ **DENTAL**

___ BASIC ___ VOLUNTARY ___ORTHO ___ DEDUCTIBLE ________________

____ **DISABILITY**

___ STD ___ LTD ___ BASIC ___ VOLUNTARY

____ **LIFE**

___ BASIC ___ VOLUNTARY AMOUNT ____________________________

CURRENT MEDICAL COVERAGE? **YES / NO** LENGTH OF COVERAGE____________

CURRENT CARRIER ______________ ER CONTRIB __________% EE _________ % DEP

CURRENT RATES- E__________ ES___________ EC___________ FAMILY___________

GROUP'S CARRIER OF WORKMAN'S COMP ___________________________________

EXISTING MEDICAL CONDITIONS____

____

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