

REQUEST FOR A QUOTE



Date:
 Need Quote by:
 Proposed Effective Date:

Prospect's Name & Address

| |
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| |
|--|

Other Locations

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| |
|--|

Nature of Business:

Description of Present Coverage

| |
|--|
| |
|--|

Present Fully Insured or Stop-Loss Rates

| | | |
|----------------------------|--------------|----------------------|
| EE | EE +1 | EE +2 or more |
| | | |
| Specific Retention: | | |
| <u>Aggregate Factors</u> | | |
| EE | EE +1 | EE +2 or more |
| | | |

COVERAGES REQUESTED

| | Option I | Option II | Option III |
|---|-----------------|------------------|-------------------|
| Specific Retention: | | | |
| Terms: | | | |
| Aggregate Coverage: | | | |
| Terms: | | | |
| Include in Aggregate: | | | |
| Basic Life/AD&D: | | | |
| Present Basic Life Rates: | | | |
| Present AD&D Rates: | | | |
| Voluntary Life: (described) | | | |
| Long Term Disability: (described) | | | |

EMPLOYER CONTRIBUTIONS

| <u>Medical Plan(s)</u> | | | <u>Other Coverages</u> | | |
|------------------------|-------------|-----|------------------------|-------------|--|
| | Self-Funded | HMO | PPO | | |
| Single: | | | | Basic Life: | |
| Dependents: | | | | LTD: | |
| CENSUS | | | COMMISSION | | |
| Single: | | | | Stop-Loss: | |
| Family: | | | | Basic Life: | |

SELF-FUNDED BENEFITS / NOTES

MEDICAL CONDITIONS

Select office to send form to: [CA](#) [CO](#)