

GROUP QUOTE REQUEST FORM: 2-50 Lives

AGENT INFORMATION									
DATE									
AGENT NAME									
PHONE NUMBER									
FAX NUMBER									
EMAIL									
GROUP INFORMATION									
GROUP NAME					PHONE				
CONTACT PERSON					FAX				
NATURE OF BUSINESS					SIC				
ADDRESS					REQUESTED EFFECTIVE DATE				
CITY		STATE		ZIP		WORKERS COMP CARRIER			
COUNTY					CURRENT CARRIER				
Total Number of people on census:						Are there any union employees?			YES / NO
Has the company been active for 5+ years?				YES / NO		Amount (%) paid by employer for employee?			
Amount (%) paid by employer for dependents?									

HEALTH CARRIERS					ANCILLARY CARRIERS				
Aetna					Shenandoah			Jefferson Pilot	
HealthAmerica					Principal			The Hartford	
Highmark					Met Life			Aetna	
UPMC					Guardian			United Concordia	
United Healthcare					Highmark Life & Casualty			Dominion	
Principal					PRODUCTS:				
					Dental	Life	LTD	STD	Vision

NOTES:



GROUP CENSUS

Please list ALL full-time eligible employees – even those waiving for spousal or other coverage.
 Incomplete information will delay the quoting process. Must include last name for Highmark quote.

	FIRST & LAST NAME	DOB (MM/DD/YY)	SEX	S I N G L E	P A R & C	P A R & C H R N	2 - P E R S O N	F A M I L Y	W A I V E R S	TOTAL NO. OF CHILDREN	ZIP	SALARY (Required for Disability)	OCCUPATION (Required for Disability)
1													
2													
3													
4													
5													
6													
7													
8													
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