



WHAT IS NEEDED TO QUOTE – SMALL & MID-SIZE GROUP (25-99)

Employer Name:

Employer Address:

Contact Person Name:

Contact Person Title, Phone and Email Address:

Total Number of Employees:

Number of Employees Covered Under Your Health Plan:

Employee Contribution Amounts:

Renewal Date (or Effective Date Proposed):

Census for each type of plan to be quoted.

Interest in Quoting:

Medical

Dental

Vision

Life: Amount: _____

Short Term Disability

Long Term Disability

Census Data:

Employee Name

Employee Date of Birth

Male or Female

Employee Home Zip Code

Employee Status on each plan – Medical, Dental, Vision, Life, LTD, STD, Voluntary Life, etc... (Employee Only, EE + Spouse, EE + Child(ren), Family)

If more than one plan is available for any benefit, please give which plan the participant is enrolled in.

FOR GROUPS UNDER 100 ELIGIBLE EMPLOYEES, NEW ACA RULES REQUIRE THAT YOU NEED DEPENDENT INFORMATION IF THEY ARE TO BE QUOTED.

If you would like to see any dependent rates, please also get me the following on the participating dependents:



- Dependent Male or Female
- Spouse or Child
- Dependent Date of Birth
- Dependent Home Zip Code (sometimes children do not live with their parents)

If quoting any disability plans, please include Salaries (up to \$120,000) and job title.

IF CURRENTLY COVERED:

Copies of all current Schedule of Benefits (SBC's for Medical) for any current plans to be quoted.

Copy of all current carrier monthly billings (for all offered, including medical, dental, vision, disability, voluntary plans, life, etc.).

Current monthly rates for each plan offered. If/when renewal rates are received, a copy of the renewals if applicable (to see rate increases, decreases, etc.).

What month is your renewal or what month would like us to have the quotes effective?

[Upload Documents Here](#)