Company Information **Request for Quote:**

Company Name:

Street Address:

City, State, Zip:

Contact Person:

Telephone: Fax:

E-Mail:

Nature of Business:

Years in business:

Federal Tax I.D.# SIC Code:

Full-time employees: Eligible employees:

Part Time/Seasonal Employees: COBRA Continues:

Carrier Information:

Current Carrier

Years with Current Carrier:

Employee Waiting Period: Renewal/Effective Date:

Employer Contribution: Employee % Dependent %

Plan Information:

Deductible: Office Visit Co-Pay

Co-Insurance: Drug Card Co-Pays

Stop Loss: Maternity:

Current Rates: Employee Only $ $ Employee/Spouse

Employee/Child $ $ Family

Renewal Rates: Employee Only $ $ Employee/Spouse

Employee/Child $ $ Family

Any additional benefits:

Things you would like to change:

Employee Census:

Group Name ________________________________

Coverage Type: **EO** – Employee Only **ES** – Employee/Spouse **EC** – Employee/Child **FAM** - Family

Name	Sex	Emp. DOB	Spouse DOB	Child DOB	Child DOB	Child DOB	Coverage Requested	Home Zip Code

****Print and Attach additional pages as necessary to list all employees****

P.O. Box 56166 Little Rock, AR 72215 * (501) 225-4485 * (501) 225-0084 *fax*

Medical • Life • Business • Auto • Home