Print Form Submit by E-mail

benefit design associates, ltd.

GROUP QUOTE REQUEST FORM

Date Requested: _____

Company Name: _____

Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Bid Deadline: _____ Nature of Business: _____

Address: _____

Other Locations: _____

CARRIER INFORMATION

Present Carrier(s) Medical _____ How Long _____

Dental _____ How Long _____

Life _____ How Long _____

Disability _____ How Long _____

Renewal Date: _____

Prior Carriers: _____

CURRENT CONTRIBUTION

Employer Pays:	Employee Cost	Dependent Cost
Medical	_____%	_____%
Dental	_____%	_____%

QUOTES DESIRED

Medical: ___HMO ___PPO ___Partially Self Funded ___HSA

Dental: ___DMO ___PPO

Life: Face amount requested $_____ Employer Paid ___ Voluntary___

ShortTerm Disability: _____ Long Term Disability: _____

(Please include salaries and occupation on census)

CENSUS INFORMATION

We will need the following information on your employees:

1. Employee name

2. Male or female

3. Date of birth

4. Job title

5. Monthly earnings

6. Enrollment status: Employee ee + Spouse ee + Child(ren) Family

Link to form if needed _____

CURRENT/REQUESTED DENTAL BENEFITS AND COSTS

	Benefit		Current	Renewal
Dental				
Cal. Year Maximum	_____	Employee	$ _____	$ _____
Cal. Year Deductible	_____	EE+SP	$ _____	$ _____
Preventative	_____	EE+CH	$ _____	$ _____
Major	_____	Family	$ _____	$ _____
Orthodontics	_____		$ _____	$ _____

CURRENT/REQUESTED DENTAL BENEFITS AND COSTS

	Current	Requested		Current Premium
Medical				
Calendar Year Ded	_____	_____	Employee	$ _____
Coinsurance %	_____	_____	EE+SP	$ _____
Dr. Office Visit Co-Pay	_____	_____	EE+CH	$ _____
Rx	_____	_____	Family	$ _____

Please provide a copy of plan renewal.