HEALTH INSURANCE QUOTE REQUEST FORMS

(Groups of 2-50 Eligible Employees)

Name of Company	Type of Company
Address	**Contact Person**
City **State** **Zip**	**Tel #** **Fax #**

Total # of Employees	
Full-time	
Part-time	
Union	

Status Breakdown:	
Single	
Married	
Emp. with child(ren)	
Family	

Current Carrier	Renewal Date

Current Plan Design (Please provide plan summary, if available)

Office Visit Copay	Hospital Copay	RX Cards		
$	$	Generic $	Brand $	Non-formulary $
Deductible		**Coinsurance %**	**Riders**	
Single $ / Family $				

Current Rates (Please provide copy of current bill, if available)

Single	Married	Emp. with child(ren)	Family
$	$	$	$

Plans to be Quoted ☐ Increase Benefits ☐ Lower Cost & Maintain Benefits

Comments: