Group Quote Request Form

Group Details

Company Name _____

Company Address _____ State _____ Zip _____

FEIN _____ Number of Employees _____ Full Time _____ Part Time _____

Business Description _____ SIC (if known) _____

Primary Contact _____ Phone _____ Email _____

Billing Contact _____ Phone _____ Email _____

Quoting Benefits Check List

- ☐ Census (ages/DOB, zip code)
- ☐ Loss History (last 2-3 years if any, available with current carrier)
- ☐ Current Benefits (If any SBC/Policy Documents, Pricing, Network)

Requested Benefits

- ☐ Medical Plans
- ☐ Minimum Essential Coverage (MEC)
- ☐ Dental & Vision Insurance
- ☐ Short Term & Long Term Disability
- ☐ Life Insurance (Term, UL, Whole)
- ☐ Hospital, Accident, Critical Illness & Cancer
- ☐ Other _____