

# Group Quote Request Form

Date: \_\_\_\_\_

**ALL FIELDS WITH AN ASTERISK (\*) MUST BE COMPLETED IN ORDER FOR A QUOTE TO BE ISSUED.**

**AGENT INFORMATION** (If no agent information is provided, an agent will automatically be assigned)

Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**GROUP INFORMATION**

\*Company Name: \_\_\_\_\_

\*Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_

\*Contact Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_ \*E-mail: \_\_\_\_\_

\*SIC Code: \_\_\_\_\_ Nature of Business: \_\_\_\_\_ \*Renewal Date: \_\_\_\_\_

\*Current Carrier: \_\_\_\_\_ \*Total Number of Full-Time Employees: \_\_\_\_\_ \*Total Number enrolled: \_\_\_\_\_

**CURRENT RATES** (Please list or attach a copy of the most recent renewal)

\*Employee Only: \_\_\_\_\_ \*Employee and Child(ren): \_\_\_\_\_

\*Employee and Spouse: \_\_\_\_\_ \*Employee and Family: \_\_\_\_\_

**RENEWAL RATES** (Please list or attach a copy of the most recent renewal)

Employee Only: \_\_\_\_\_ Employee and Child(ren): \_\_\_\_\_

Employee and Spouse: \_\_\_\_\_ Employee and Family: \_\_\_\_\_

**CURRENT BENEFITS** (Please list or attach a copy of the benefit highlight sheet)

\*Deductible: \_\_\_\_\_ \*Office Visit: \_\_\_\_\_

\*Family Deductible: \_\_\_\_\_ \*Rx Drugs: \_\_\_\_\_

\*Coinsurance: \_\_\_\_\_ Emergency Room: \_\_\_\_\_

\*Out of Pocket Maximum: \_\_\_\_\_ Preventive Care: \_\_\_\_\_

\*Family Out of Pocket Max: \_\_\_\_\_

**\*CENSUS**

Please include a census that lists all eligible employees. The census should be completed in an electronic format and include employee name, gender, date of birth and coverage tier.

**ADDITIONAL PRODUCTS** (Please indicate interest in any additional product – check all that apply)

- |                                                     |                                                                |
|-----------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Flexible Spending Accounts | <input type="checkbox"/> Health Reimbursement Accounts         |
| <input type="checkbox"/> COBRA Administration       | <input type="checkbox"/> Medical Reimbursement Plans           |
| <input type="checkbox"/> Health Savings Accounts    | <input type="checkbox"/> Transportation Reimbursement Accounts |

Notes: \_\_\_\_\_

Please email the completed form, along with an employee census, to [quotes@flexiblebenefit.com](mailto:quotes@flexiblebenefit.com) or fax to 847-699-6906. For questions about completing this form, please call Flex at 847-699-6900.

