

# Benefit Choices, Inc.

## Request for Insurance Quotes—Company Data

**Company Information:**

Company Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Website: \_\_\_\_\_

**Contact Information:**

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Does this group employ more than 50 F/T employees? \_\_\_\_\_  
 Are you the person who makes the final decisions about your company's health care? If not, please include their name and phone number: \_\_\_\_\_

**Information about the type of health plan you want for your employees:**

<b>Preferred Plan Type</b>	<input type="checkbox"/> Traditional Indemnity	<input type="checkbox"/> Point of Service (HMO w/ Opt-Out)
	<input type="checkbox"/> HMO	<input type="checkbox"/> Preferred Provider Network

Health Coverage	In Network	Out of Network		In Network	Out of Network
Co-Insurance	%	%	Primary Co-Pay	\$	N/A
Deductible:	\$	\$	Specialist Co-Pay	\$	N/A

Prescription Drug Coverage		RX Generic	RX Formulary	RX Non-Formulary
RX Deductible:	\$	Co-Pays:		

1. Do you currently provide health coverage as a benefit for your employees? YES      NO  
 If yes, what is your current carrier and plan type? \_\_\_\_\_
  
2. If you currently provide health coverage as a benefit for your employees, what is your renewal date?  
 Date: \_\_\_\_\_
  
3. Are you also requesting quotes for other benefits at this time? YES      NO  
 Please list: \_\_\_\_\_

**Additional Comments:**

**Survey Information**

If you have a minute, we would greatly appreciate your response to the questions below.

1. How did you hear about us? \_\_\_\_\_
2. Have you seen our website? \_\_\_\_\_
- 3a. Do you have a website for your business? \_\_\_\_\_
- 3b. If not, are you interested in having one? \_\_\_\_\_

# Benefit Choices, Inc.

## Request for Insurance Quotes—Census Data Page 1

Employee Name	Date of Birth	Hours/Week	Coverage (IND, EMP+I, FAM)	M/F	Occupation	Salary (Required for Life, STD, & LTD only)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

# Benefit Choices, Inc.

## Request for Insurance Quotes—Census Data Page 2

Employee Name	Date of Birth	Hours/Week	Coverage (IND, EMP+I, FAM)	M/F	Occupation	Salary (Required for Life, STD, & LTD only)
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
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49						
50						

# Benefit Choices, Inc.

## Request for Ancillary Benefits Quote—Information Form

Company Name: \_\_\_\_\_  
 Company Contact Name: \_\_\_\_\_  
 Contact Phone #: \_\_\_\_\_

Office Use Only	
Curr. Health Client?	Y__ N__
Sub. W/ Health Quote?	Y__ N__

<b>DENTAL</b>	<input type="checkbox"/> Non-Contributory <input type="checkbox"/> Contributory <input type="checkbox"/> Voluntary
<input type="checkbox"/> DMO _____ <input type="checkbox"/> PPO _____ <input type="checkbox"/> Indemnity _____	
Plan Design: _____ Orthodontic: _____	
Deductible: _____ Takeover: _____	
Employee Participation: _____ Employer Contribution: (EE) _____ (DEP) _____	
Options: _____	

<b>VISION</b>	<input type="checkbox"/> Non-Contributory <input type="checkbox"/> Contributory <input type="checkbox"/> Voluntary
Employee Participation: _____ Employer Contribution: (EE) _____ (DEP) _____	
Notes: _____	

<b>LONG TERM DISABILITY</b>	<input type="checkbox"/> Non-Contributory <input type="checkbox"/> Contributory <input type="checkbox"/> Voluntary
Benefit %: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____	
Maximum: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> Other _____	
Elimination Period: <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days <input type="checkbox"/> Other _____	
Benefit Period: <input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 67/SSNRA <input type="checkbox"/> Other _____	
Definition of Disability: _____ Zero Day Residual: _____	
Options: _____	

<b>SHORT TERM DISABILITY</b>	<input type="checkbox"/> Non-Contributory <input type="checkbox"/> Contributory <input type="checkbox"/> Voluntary
Benefit %: <input type="checkbox"/> Flat <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____	
Maximum: <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Other _____	
Elimination Pd. (inj.): <input type="checkbox"/> 1 Days <input type="checkbox"/> 8 Days <input type="checkbox"/> 14 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> Other _____	
Elimination Pd. (ill.): <input type="checkbox"/> 8 Days <input type="checkbox"/> 14 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> Other _____	
Benefit Period: <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 12 <input type="checkbox"/> 25 <input type="checkbox"/> Other _____	
Options: _____	

<b>LIFE / AD&amp;D</b>	<input type="checkbox"/> Non-Contributory <input type="checkbox"/> Contributory <input type="checkbox"/> Voluntary
Schedule: <input type="checkbox"/> Flat <input type="checkbox"/> 1 X <input type="checkbox"/> 2 X <input type="checkbox"/> 3 X <input type="checkbox"/> Other _____	
Maximum: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other _____	
Age Reduction: _____ GI Limit: _____	
Optional/Supp: _____ Dependent: _____	
Options: _____	