

# Small Group Quote Request

Effective date:	
Send quote to:    Broker    Company contact person	Via:    E-mail    Fax    Mail

## Please tell us about your company.

Company name:		Number of employees: National: _____ Local: _____	
Contact person:			
Type of business:			
Street address:		City:	State:                  ZIP:
E-mail address:			
Phone number:		Fax number:	

Current carrier of group medical plan:	
If Group Health, group number:	
Current group benefits:	
Broker's name:	
Broker's email address:	
Broker's fax number:	
Current rates: Employee: _____ Spouse: _____ Children: _____	Renewal rates: Employee: _____ Spouse: _____ Children: _____

## Please list employees who will be covered.

1	Employee name	Employee date of birth*	Employee age (optional)	Spouse (yes or no)*	Spouse's date of birth*	Spouse's age (optional)	Number of children to be covered*
2							
3							
4							
5							
6							
7							
8							
9							
10							

*\*Required fields*

We can provide a more accurate quote with complete information. For more than 10 employees, please use an additional sheet. Please fax this form, and any additional sheets, to 206-877-0654.