



**Information Questionnaire**

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Medical 1 \_\_\_\_\_ Renewal Month \_\_\_\_\_

Rates: EE \$ \_\_\_\_\_

EE/SP \$ \_\_\_\_\_

EE/CH \$ \_\_\_\_\_

Fam \$ \_\_\_\_\_

Medical 2 \_\_\_\_\_ Renewal Month \_\_\_\_\_

Rates: EE \$ \_\_\_\_\_

EE/SP \$ \_\_\_\_\_

EE/CH \$ \_\_\_\_\_

Fam \$ \_\_\_\_\_

Dental \_\_\_\_\_ Renewal Month \_\_\_\_\_

Rates: EE \$ \_\_\_\_\_

EE/SP \$ \_\_\_\_\_

EE/CH \$ \_\_\_\_\_

Fam \$ \_\_\_\_\_

Other \_\_\_\_\_ Renewal Month \_\_\_\_\_

Which Coverage's would you like a quote for?

Medical 1    Medical 2    Dental    Other \_\_\_\_\_

**ELIGIBILITY:**

Minimum Hours to be Eligible: \_\_\_\_\_

Probationary Period (coverage begins): \_\_\_\_\_

**Employers** Contribution to Medical Coverage: EE \_\_\_\_\_ %, DEP \_\_\_\_\_ %

Dental Coverage: EE \_\_\_\_\_ %, DEP \_\_\_\_\_ %

**COBRA:**

COBRA Eligible:    Yes    No

Current EE's on COBRA: \_\_\_\_\_

How long have you been with your current Carrier Company \_\_\_\_\_

If less then 3 years, please provide the Previous Carrier(s) information \_\_\_\_\_

