

- 1. Print this form, then complete the requested information.**
- 2. Fax your completed form to 1-913-663-4675**

Practice Name \_\_\_\_\_ Contact \_\_\_\_\_  
 Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_ Fax No. \_\_\_\_\_

Employee Name	Sex M/F	Employee Age	Coverage Codes (See Below)	Spouse Age	Number of Children	Employee Status Codes	Smoker (Y/N) (Emp./Sp.)	Current Premium
							/	
							/	
							/	
							/	
							/	
							/	
							/	

**\*\*\*List all employees even if they are not on the company insurance plan. You can indicate that they are covered under "Current Premium".\*\*\*** If there are more than 7 employees, please make a copy of this form to include all employees.

**COVERAGE CODES**

S = Employee Only      F = Family  
 ES = Employee + Spouse      L = Life Only  
 EC = Employee + Child

**EMPL. STATUS CODES**

FT = Full Time  
 PT = Part Time  
 CO = Cobra

How much is your total health premium? \_\_\_\_\_ Desired Deductible? \_\_\_\_\_  
 Coinsurance Amount? (IN-Network/Out-Of-Network, i.e. 90%/80%) \_\_\_\_\_  
 Dr. Office Copay Amount Desired? \_\_\_\_\_ Current Deductible? \_\_\_\_\_

Maternity covered same as any other illness? Y or N  
 Would you like to include dental benefits? Y or N  
 Would you like Term Life Insurance? Y or N      In what amount? \_\_\_\_\_

Please list the current health conditions in your group (asthma, heart, cancer, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who will make the final decision on your health care plan? \_\_\_\_\_  
 What effective date would you like on this quote? \_\_\_\_\_

Once your completed information is received, your personalized quote will be mailed to you right away.

**If you have questions, please call 1-877-393-0519.**