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GROUP BENEFITS QUOTE REQUEST

Agent(s): \_\_\_\_\_  
Original Appointment Date: \_\_\_\_\_ **Follow-up Appointment Date (if scheduled):** \_\_\_\_\_

I. Client Profile

- \_\_\_ Legal Name
- \_\_\_ Address
- \_\_\_ County
- \_\_\_ Phone/Fax #
- \_\_\_ Contact Name
- \_\_\_ Nature of Business/SIC Code
- \_\_\_ Workers Compensation Carrier
- \_\_\_ Current Census – See Attached *Employee Census Information Form*
- \_\_\_ Copy of Most Recent Form UC-2 (PA State Unemployment Tax Form)  
Please indicate which employees are ineligible and reason (ie. Part-time, covered under spouse, etc.)
- \_\_\_ Waiting period for new hires
- \_\_\_ Employee Contribution %
- \_\_\_ Sect. 125 (Employee contributions on “pre-tax basis”?)

For groups of 50 or more employees

- \_\_\_ Claims experience for prior two years (if available)
- \_\_\_ Details of claims in excess of \$25,000 in past 12 months (diagnosis, prognosis, \$ amount)

II. CURRENT COVERAGES\*

- \_\_\_ **Life & AD&D** Rate: \_\_\_\_\_  
Amount: \_\_\_\_\_
- \_\_\_ **Dependent Life** Rate: \_\_\_\_\_  
Amount: \_\_\_\_\_
- \_\_\_ **Short Term Disability (STD)** Rate: \_\_\_\_\_  
Elimination Period: \_\_\_\_\_  
Benefit Period: \_\_\_\_\_  
Benefit Amount (% of Income): \_\_\_\_\_
- \_\_\_ **Long Term Disability (LTD)** Rate: \_\_\_\_\_  
Elimination Period: \_\_\_\_\_  
Benefit Period: \_\_\_\_\_  
Benefit Amount (% of Income): \_\_\_\_\_
- \_\_\_ **Vision** Rate: \_\_\_\_\_  
Deductible: \_\_\_\_\_  
Benefit Amounts: \_\_\_\_\_
- \_\_\_ **Dental** Rate: \_\_\_\_\_  
Deductible: \_\_\_\_\_  
Benefit Amounts: \_\_\_\_\_
- \_\_\_ **Medical** Rates: \_\_\_\_\_  
Plan Type (PPO, HMO, etc.): \_\_\_\_\_  
Physician Office Copay: \_\_\_\_\_  
Deductible: \_\_\_\_\_  
Coinsurance: \_\_\_\_\_

III. QUOTES REQUESTED

- \_\_\_ **Life & AD&D**  
Amount: \_\_\_\_\_
- \_\_\_ **Dependent Life**  
Amount: \_\_\_\_\_
- \_\_\_ **Short Term Disability (STD)**  
Elimination Period: \_\_\_\_\_  
Benefit Period: \_\_\_\_\_  
Benefit Amount (% of Income): \_\_\_\_\_
- \_\_\_ **Long Term Disability (LTD)**  
Elimination Period: \_\_\_\_\_  
Benefit Period: \_\_\_\_\_  
Benefit Amount (% of Income): \_\_\_\_\_
- \_\_\_ **Vision**  
Deductible: \_\_\_\_\_  
Benefit Amount: \_\_\_\_\_
- \_\_\_ **Dental**  
Deductible: \_\_\_\_\_  
Benefit Amounts: \_\_\_\_\_
- \_\_\_ **Medical**  
Plan Type: \_\_\_\_\_  
Physician Office Copay: \_\_\_\_\_  
Deductible: \_\_\_\_\_  
Coinsurance: \_\_\_\_\_

\*In lieu of completing the “Current Coverages” information, a copy of the current carrier’s most recent invoice and benefits booklet can be submitted.

(pghbenefitsllcgroupfp.doc)

***Employee Census Information***

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

Agent Name(s) \_\_\_\_\_

<b>Name</b>	<b>Sex</b>	<b>Date of Birth</b>	<b>Date of Hire</b>	<b>Relationship Code*</b>	<b>Home Zip Code</b>	<b>Occupation</b> <i>Required for Disability Quotes Only</i>	<b>Annual Income</b> <i>Required for Disability Quotes Only</i>
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\*E=Employee, SP= Spouse, C= Child

