



# Employee Benefits Insurance Request Form

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

Entity Type:  Individual  DBA  LLC  Corporation  Other \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Best Time of Day  AM  PM  OTHER \_\_\_\_\_

Website Address \_\_\_\_\_ Best Way to Contact  Phone  Email  OTHER \_\_\_\_\_

Description of Business Operations \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Desired Effective Date \_\_\_\_\_

\*Paperwork must be submitted no later than the 15th of the month for an effective date of the 1st of the following month.

Suggested Options for Proposal:  HMO  EPO  PPO  HSA  Co-Pay \_\_\_\_\_  Deductible/Co-Pay \_\_\_\_\_

# of Employees \_\_\_\_\_ # of Employees going on plan \_\_\_\_\_

# of Employees Declining Coverage & Not Covered Under Spouse \_\_\_\_\_

For employees enrolling, how many:  
 Single \_\_\_\_\_  
 2-Person \_\_\_\_\_  
 Employee/Child(ren) \_\_\_\_\_  
 Family \_\_\_\_\_

Riders  
 Dependent/Student Age \_\_\_\_\_  
 Rx \_\_\_\_\_  
 Dental \_\_\_\_\_  
 \_\_\_\_\_

Upon completion of this form please click on the [Email Form](#) button at the top of this document.

Once the form is received by our agency, an Account Executive will contact you. Please note that completing the above information in no way constitutes bound coverage. In order to quote we may need additional information such as, but not limited to, employee census, current plan information, current rates, and tax documents.