Group Request Form

Agency Name:			
Agent Name:			
Street			
City			
State		Zip	
Phone Number			
Fax Number			
Email Address			

Client Name:			
Street			
City			
State		Zip	
Contact Person			
Phone Number			
Fax Number			
Sic Code			

Known Existing Medical Conditions Hold the "Ctrl" Key for multiple Selections. If additional information can be provided please do so in the comments section at the bottom of page two	Pregnancy HBP Allergy Aids Heart Attack Cancer MS Other

Coverage Desired

Doctor Co-Pay	○ Yes	○ No
Drug Card	○ Yes	○ No
Group Life	○ Yes	○ No
Dental	○ Yes	○ No
Short Term DI	○ Yes	○ No
Long Term DI	○ Yes	○ No

Life Amount	15000

If DI is desired, use page three of this form to provide income and zip code Information

Plan Type	PPO
Hospital Ded	100
Co Insurance	100%
Preferred Company	None

Census Information

List all employees

Name	Gender		AGE/DOB	Spouse Age/DOB	Coverage	No. of Children
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One
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Employee	○ Male	○ Female			Employee Only	One
Employee	○ Male	○ Female			Employee Only	One

Additional Requests or Comments

Group DI Census Information

Name		Salary	Zip Code
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
Employee			
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