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**REQUIRED INFORMATION FOR GROUP QUOTES**

**Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Nature of business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Number of years in business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Current Carrier and years with current carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Next Renewal Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Current Rates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Current Monthly Billing
7. 3 Years Claims Experience and rates
8. Current Plan Design or (Booklet)
9. Employee Data (Sheet Provided for you to fill) 9a. Number of pay periods/yr: \_\_\_\_\_\_\_\_

9b. Employer premium contribution to health and dental: (minimum 50%): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Employee Status Data (Is anyone off work for any reason)

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11. Additional info

A. Are all employees covered for WCB? Yes No

B. Do all employees work a minimum of 24 hours per week? Yes No

C. Are they unionized? Yes No

 12. Have there been any Long Term Disability claims in the last 36 months? Yes No

 If Yes, any additional info about claims/nature of Disability and when are they back to work:

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 13. Website\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_