

HEALTH & DENTAL GROUP QUOTE - WISCONSIN RESIDENTS ONLY

General Information

Contact Name _____
Contact Email _____
Name of Business _____
Nature of Business _____
Address _____
City, State ZIP _____
Business Phone _____
Cell Phone _____
Fax _____

Life & Accidental Death & Dismemberment

of Employees _____
of Eligible Employees _____
Current Carrier _____
Renewal Date _____
Current Rate _____

Group Health Coverage

Number of Employees _____
Number of Eligible Employees _____
Current Plan _____
Desired Deductible _____
Desired Co-Pay _____
Desired Co-Insurance _____

Group Dental Coverage

Number of Employees _____
Number of Eligible Employees _____
Current Plan _____
Desired Deductible _____
Desired Co-Insurance _____
Calendar Year Maximum _____

Group Disability Coverage

Number of Employees _____
Number of Eligible Employees _____
Current Plan Short Term Disability _____ Long Term Disability _____
Current Carrier _____
Renewal Date _____
Current Rates - STD _____
Maximum Benefit - STD _____
Current Rates - LTD _____
Maximum Benefit - LTD _____