

# GROUP ANCILLARY QUOTE REQUEST

## GENERAL REQUIREMENTS:

Employees listed on census, must be W2 or K1 of the business  
Minimum of 2 eligible employees (30+ hours/week)  
Business operating for minimum of 1 year  
Less than 50% of eligible employees related

### DATE QUOTE IS NEEDED BY

Date

### COVERAGE EFFECTIVE DATE

Date

## INFORMATION NEEDED TO QUOTE GROUP ANCILLARY:

### PRODUCTS OF INTEREST

- |                               |  |   |                                      |                                 |
|-------------------------------|--|---|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Life | <input type="checkbox"/> Voluntary Term Life   | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Dental      | <input type="checkbox"/> Vision |
| <input type="text"/>          | <input type="checkbox"/> Short-Term Disability | <input type="checkbox"/> Critical Illness   | <input type="checkbox"/> Other _____ |                                 |
| Amount                        | <input type="checkbox"/> Long-Term Disability  | <input type="checkbox"/> Hospital Indemnity | _____                                |                                 |

### BUSINESS NAME & ADDRESS

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

### CONTRIBUTION

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Employer Paid | <input type="checkbox"/> Voluntary |
| <input type="text"/> %                 | <input type="text"/> %             |
| Employer Paid                          | Employee Paid                      |
| <input type="checkbox"/> Co-Funded     |                                    |
| <input type="text"/> %                 | <input type="text"/> %             |
| Employer Paid                          | Employee Paid                      |

### PLAN

- |  |   |
|--|---|
| <input type="checkbox"/> Takeover<br>Existing Carrier In-Force | <input type="checkbox"/> Start-Up Coverage<br>New Coverages |
|--|---|
- If takeover, please provide the following:  
Current carrier(s) name (if available): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Current plan design(s) and rates per product line (if available):  
\_\_\_\_\_  
\_\_\_\_\_

### OTHER REMARKS

\_\_\_\_\_  
\_\_\_\_\_

