Dear Owner,

In providing you the best possible service and giving you an accurate proposal, if you could please take a few minutes and provide us the following information;

Legal Name of Company: _____

SIC Code / Industry: _____

Company Address: _____

City: _____ St: _____ Zip Code: _____

Company Point of Contact: _____

Phone: _____ Email: _____

Do you currently have a company Health Plan? ☐ Yes ☐ No

If Yes, please provide name of carrier: _____ Renewal Date: _____

Full Time – W2 Employees: _____ (+30 hours or more per week)

Part Time – W2 Employees: _____ (-29 hours or more per week)

Expected Effective Date: _____

Employer Monthly Contribution: % _____ Monthly Budget: $_____

Plan Preference: (check all that apply)

- ☐ PPO
- ☐ HMO
- ☐ HSA

Other Interests: (check all that apply)

- ☐ Dental
- ☐ Vision
- ☐ Life
- ☐ Short Term Disability
- ☐ Long Term Disability

The information supplied will be utilized to produce a comprehensive proposal for your company.

Thank you for your consideration,