



# M. Brown & Associates, Ltd.

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## GROUP QUOTE REQUEST

Company Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SIC Code: \_\_\_\_\_

Exact Nature of Business: \_\_\_\_\_

## EMPLOYEE INFORMATION

Total number applying for medical: \_\_\_\_\_ Total number for life: \_\_\_\_\_ Total full-time employees: \_\_\_\_\_

How many on COBRA \_\_\_\_\_ (Please inform us if COBRA insured are on due to sickness or injury)

How many employees are related by blood or marriage: \_\_\_\_\_

## REQUESTED QUOTE INFORMATION

DEDUCTIBLE  
\_\_\_\_\_ 250  
\_\_\_\_\_ 500  
\_\_\_\_\_ 1000  
\_\_\_\_\_ Other

CO-INSURANCE  
\_\_\_\_\_ 100/90  
\_\_\_\_\_ 90/70  
\_\_\_\_\_ 80/60  
\_\_\_\_\_ Other

STOP LOSS/OOP  
\_\_\_\_\_ 2500 \_\_\_\_\_ PPO  
\_\_\_\_\_ 5000 \_\_\_\_\_ HMO  
\_\_\_\_\_ In-Network \_\_\_\_\_ Out-of-Network  
Desired Effective Date: \_\_\_\_\_  
Renewal Date: \_\_\_\_\_

## CURRENT PLAN INFORMATION

Current Carrier: \_\_\_\_\_  
Current Monthly Premium \$ \_\_\_\_\_  
Renewal Monthly Premium \$ \_\_\_\_\_  
Current Deductible: \_\_\_\_\_  
Current co-ins: \_\_\_\_\_  
Current Stop Loss: \_\_\_\_\_  
OOP: \_\_\_\_\_ In-Network: \_\_\_\_\_ Out-of-Network

Premium Includes:  
\_\_\_\_\_ Maternity \_\_\_\_\_ Carry Over Credit  
\_\_\_\_\_ Dental \_\_\_\_\_ Enh Prev Care  
\_\_\_\_\_ Sup Accident \_\_\_\_\_ Drug Card  
\_\_\_\_\_ Office Visit Copay Network: \_\_\_\_\_  
\_\_\_\_\_ Life Insurance Other: \_\_\_\_\_

## OTHER

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