FACT FINDER

GROUP INFORMATION: *(All information in this section is required)*

Group Name:_____ Phone #: _____
Contact:_____ # years in business:_____
Business Address:_____
City:_____ County:_____ State: CA Zip:_____
Nature of Business:_____ # of locations:_____
Group Coverage currently in force since:_____ Renewal Month:_____
Name of Carrier:_____

MEDICAL INFO-ALL GROUPS:

Has any employee or dependent had any claims within the past 12 month in excess of $10,000?
☐ Yes ☐ No If Yes, for what reason: _____
Insured for Medical:_____ # of eligible Full-Time Employees*:_____
*NOTE: Employees who work 30 + hours per week are considered full time.

Employer contribution: Per Employee:_____ Dependents:_____

CURRENT PLAN/BENEFIT DESCRIPTION: *(Please attach current carrier benefits)*

HMO-Office Co-Pay:_____ Hospital Stay Co-Pay: _____ RX Co-Pay: _____
PPO-In Panel Co-Pay:_____ Hospital Stay Percentile: _____ % _____%

☐ **CURRENT RATES** ☐ **RENEWAL RATES** ☐ **COMPOSITE**

Employee Only (EE): _____ Empl + Spouse (E+S): _____
Empl + Child(ren) (E+C): _____ Empl + Family (E+F): _____
Age Banded Total Premium: _____

***BENEFITS REQUESTED *** *(All information in this section is required)*

Coverage interested in *(check all that apply)*:

MEDICAL ☐ HMO ☐ PPO
DENTAL ☐ HMO ☐ PPO
☐ VISION ☐ LIFE

Effective Date Requested:_____
Other:_____

1430 E. Cooley Drive
Colton, CA 92324
LIC. 060532

EPR Insurance Services

Office: 951.763.8810
Toll Free: 866.569.9598
Fax: 951.767.8241
quotes@eprinsurance.com