PlanChoice, Inc.
800-466-5182
www.planchoice.com
Email quote request to: joe.russo@planchoice.com

Broker Information

Broker Firm Name:	___________________________________
Producer Name:	___________________________________
Broker Address:	___________________________________
City, State & Zip:	___________________________________
	___________________________________
Broker Phone Number:	___________________________________
Broker Email Address:	___________________________________

Group Information

Name of Group:	___________________________________	**Current Renewal Date:**	_________________
Address:	___________________________________	**Effective Date:**	_________________
City, State & Zip:	___________________________________	**Waiting Period:**	_________________
	___________________________________		
SIC Code:	___________________________________		
Nature of Business	___________________________________		
Years in Business	___________________________________		
# of Eligible Employees:	___________________________________		
# of Full Time Employees:	___________________________________		

Notes: For each line of coverage, please supply a copy of the summary benefits pages, if available.
Please provide copy of current or recent bill for each line of coverage requested.
Please provide at least 3 years expierence for quote requests of 100 or more lives.

Group Dental Insurance

Current Carrier: ______________________________

# of Employees Participating: ______________________________

Employer Paid or Voluntary: ______________________________

Current Benefits:

Current Rates: ______________________________

Renewal Rates: ______________________________

Additional Information:

Group Life and AD&D

Current Carrier: ______________________________

# of Employees Participating: ______________________________

Employer Paid or Voluntary: ______________________________

Current Rates: ______________________________

Renewal Rates: ______________________________

Group Short Term Disability

Current Carrier: ______________________________

# of Employees Participating: ______________________________

Employer Paid or Voluntary: ______________________________

Current Benefits:

Current Rates: ______________________________

Renewal Rates: ______________________________

Additional Information:

Group Long Term Disability

Current Carrier: ______________________________________

# of Employees Participating: ______________________________________

Employer Paid or Voluntary: ______________________________________

Current Benefits:

Current Rates: ______________________________________

Renewal Rates: ______________________________________

Additional Information:

Group Vision

Current Carrier: ______________________________________

# of Employees Participating: ______________________________________

Employer Paid or Voluntary: ______________________________________

Current Benefits:

Current Rates: ______________________________________

Renewal Rates: ______________________________________

Additional Information:

Additional Ancillary Benefits

Please check all that apply:

GAP Plans ___	Critical Illness ___
Group Retiree Health Plan ___	Cancer ___
Limited Benefit Health Plans ___	International Medical ___
Group Identity Theft ___	Long Term Care ___
Group Legal Program ___	Travel Accident ___
Health Now MD ___	Stop Loss ___
Accident Plans ___	

Current Carrier: ________________________________

# of Employees Participating: ________________________________

Employer Paid or Voluntary: ________________________________

Current Benefits:

Current Rates: ________________________________

Renewal Rates: ________________________________

Additional Information:

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Census

	Age/DOB	Gender	Home Zip	Occupation*	Class (If applicable)	Annual Salary*	Type of Coverage (EE, ES, EC, F) (W=Waive)	Full Time (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

***Only needed if quoting STD or LTD**