

GROUP HEALTH INSURANCE QUOTE REQUEST

Please list all full-time (30 + hours) employees who will participate in the group plan. List dependents only you wish us to quote spouse and/or dependent coverage. Dependents >18 yrs. can be included only if full-time students; list separately below.

Name of business _____

Contact _____ Capacity _____

Address _____ Phone _____ Fax _____

City _____ State _____ County _____ Zip code _____

Type and nature of business _____ # of Full-time employees (incl. owners) _____

Current group insurance co. _____

#	Employee	Age	Smoker	Spouse Age	# of Children	Employee's Zip Code	Persons to be covered ¹
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

¹Persons to be covered code: E= Employee only ES=Employee+ Spouse EC=Employee+ Children F=Full family

List desired coverage: Medical Deductible \$ _____ Dental Vision Life Disability Income _____

FAX THIS FORM TO:

Duneland Health Benefits

FAX 219-947-7860
Phone 800-772-7607