



## Quote Request Form (Groups 10+)

Name of Agent: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Agency: \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Group: \_\_\_\_\_ # of Employees: \_\_\_\_\_

Group Address: \_\_\_\_\_

Business Description: \_\_\_\_\_

Current Carrier: \_\_\_\_\_ Years: \_\_\_\_\_

### CURRENT PLAN INFORMATION

BENEFIT MAXIMUM \$ \_\_\_\_\_

DEDUCTIBLE \$ \_\_\_\_\_  Waive Class I

CLASS I \_\_\_\_\_ %

CLASS II \_\_\_\_\_ %

CLASS III \_\_\_\_\_ %

#### EMPLOYER CONTRIBUTION:

- Employee \_\_\_\_\_ % Dependents \_\_\_\_\_ %

#### ORTHODONTIA:

- Maximum \$ \_\_\_\_\_ %

Children Only

Adults & Children

#### RATES

	Current	Renewal
Employee	\$ _____	\$ _____
Emp/Sp	\$ _____	\$ _____
Emp/Ch	\$ _____	\$ _____
Family	\$ _____	\$ _____
Composite	\$ _____	\$ _____

WAITING PERIOD:  6 month  12month

Waived:  Class I & II  Class I & II R

Renewal Date: \_\_\_\_\_

\*Please attach employee census and past experience information (if available)

Plan Type Requested (Groups of 10 employees and more):

#### Annual Max.

750 Max

1,000 Max

1,500 Max

2,000 Max

#### Benefit Options

Ortho  500  750  1,000  1,500  2,000

100% Preventative, 80% Basic, 50% Major

80% Preventative, 80% Basic, 50% Major

Other: Specify \_\_\_\_\_

TMJ Rider  Implant Rider  Cosmetic Rider

Domestic Partner Rider (Check one) \_\_\_ Same Sex \_\_\_ Both Sex

Non- Member Dentist Reimbursement based on  50<sup>th</sup> %  75<sup>th</sup> %  80<sup>th</sup> %  90<sup>th</sup> %

Date Proposal is needed: \_\_\_\_\_ Effective date: \_\_\_\_\_

\*Groups with 9 or under employees should be quoted from the 2-9 rate sheet found in section 3.