

Broker Information:

Date: _____

Name: _____ License Number: _____

Agency Name: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Group Information: (Please complete all information below for best results)

Company Name: _____ City: _____ Zip: _____

Requested Effective Date: _____ Type of Business or SIC code: _____

No. of employees: _____ No. out of state: _____ No. of COBRA employees: _____

If carveout group, what kind?: _____

Current Carrier(s): _____ Employer Contribution (% or \$) EE: _____ Dep: _____

Product Selection Circle plan types your client is interested in:**Medical**

HMO

POS

PPO

Dental

DHMO, PPO, DPO, Indemnity, Voluntary

Yrs. Of Prior Coverage _____

Life

Flat Amount _____

X Salary _____

By Class _____

Quality Carriers available Aetna* - medical / dental Delta Dental Premier Access Dental & Vision American Specialty Health Golden West Dental & Vision Principal Life Blue Cross* - medical / dental Health Net Sharp Health Plan - San Diego CaliforniaChoice Health Net Dental & Vision Vision Service Plan Community Health - San Diego PacifiCare

* Please circle what you would like quoted - medical or dental

Additional Notes:

Quote Delivery: Needed by: _____ # of Copies _____ E-Mail Fax Summaries Mail full Bound Proposal Hold For Pick-Up Date: _____ Time: _____

Other: _____

