



**Please FAX to: (866) 324-7567
Attn: QUOTE DEPT.**

GROUP LIFE/AD&D/DISABILITY QUOTE REQUEST FORM

Company Name*:				City, State, Zip*:		
Nature of Business*:				Requested Effective Date*:		
Current Life/AD&D:				Current Disability:		
#	Employee Name or Initials	Job Title*	Classification	D.O.B. or Age*	Gender*	Monthly Salary*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

*Please include all full-time employees. For Disability, company must be in business 2+ years.
For additional employees, attach separate page or contact us for the 25+ and 50+ forms.*

Please indicate if you would like us to:

- Show quotes by 'classing' out certain employees
- Show varying amounts of life or disability benefits based on employee class/status
- Show specific insurance carriers:

This form is for quoting all lines of coverage.
Available electronically upon request:
quotes@benefitconsultantsinc.com

* indicates required fields.