



In order to provide your office with a Quote-Complete the form below & fax back to: **JIM MILLER**, Fax #: **201-986-1167**

Name (Office): _____

Address: _____

Contact Person: _____ Phone: _____

Current Carrier: _____ Renewal Date of Current Plan: _____

Provide a general description of the health plan(s) you offer your employees or attach current Plan Design. I.e., PPO, HMO, copay, deductible etc...

Does your plan include a prescription program? Yes No What are the Copays: _____

What is your current monthly premoum for the following coverage tiers?

Single Coverage: \$ _____ Employee & Spouse: \$ _____

Family Coverage: \$ _____ Employee & Child(ren): \$ _____

COMPLETE THE CENSUS BELOW FOR ALL EMPLOYEES

Employee Name or Initials and Title	Date of Birth (mo, dy, yr)	Gender	Date of Hire (mo,dy,yr)	Type of Coverage (Single, Employee & Spouse, Employee & Children, Family)	Hours Worked per week	Spouse Name & D.O.B.	Child & D.O.B.	Child & D.O.B.	Child & D.O.B.
Example: Dr. Chris Smith	10/20/1960	M	5/1/1998	Family	40+	Mary Smith 9/17/1962	Edward Smith 11/21/1989	Jeffery Smith 10/7/1991	Susan Smith 5/4/1993
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Additional Employes can be added on a separate piece of paper and included with this fax.