



Hoffman Benefit Services Inc.

Bob Hoffman

900 East 96th Street, Suite 300
Indianapolis, IN 46240
(317) 705-8139 • Fax (317) 469-2500

Quote Request Form

ACCOUNT NAME		TYPE OF BUSINESS		DATE
CITY	COUNTY	STATE	ZIP	EFFECTIVE DATE

PLAN REQUESTED: Traditional: 80/20 or 50/50

PPO: 90/70 or 80/60

PPO NETWORK REQUESTED (if optional): IHN, Sagamore, Encore/VHA Tri-State, PHCS, Health Span

DEDUCTIBLE OPTION: \$100 \$250 \$500 \$1,000 \$2,000 OTHER \$ _____

STOP LOSS OPTION: \$2,500 \$5,000 \$10,000

OPTIONAL BENEFITS:

Supplemental Accident (\$300 or \$500) Maternity: Yes No Rx Card: Yes No

Dependent Life: Yes No Wellness: Yes No Life Amount: \$ _____

Weekly Disability: Yes (Indicate if flat amount or by % of salary _____) No
 13 weeks 26 weeks 52 weeks

Long Term Disability: Yes (Please indicate elimination period 90 days or 180 days) No

Dental: Yes No If Yes, indicate calendar year maximum: \$500 \$1,000 \$1,500

Orthodontia Coverage: Yes No (Does the group have prior dental coverage? _____)

Current Carrier: _____ How long? _____ Current Premium: \$ _____

Are there any known health problems in this group? Yes (Please explain in detail) No



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Name	Age or Birth Date	Sex M/F	Coverage	# of Children	Life Amt. (If by salary or class)	Occupation	Annual Salary
<i>Example 1</i> Individual	30	M	E	0	\$20,000	Accountant	\$100,000
<i>Example 2</i> Family	40	F	F	4	\$20,000	Secretary	\$50,000
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COVERAGE: E = EMPLOYEE ONLY EC = EMPLOYEE & CHILD ES = EMPLOYEE & SPOUSE F = FULL FAMILY LO = LIFE ONLY
Please make a copy of this form if you have additional employees.