

REQUEST FOR GROUP HEALTH QUOTATION

Firm: _____

Return To: Lucien Wright Insurance

Address: _____

1200 W. Freeway, Suite 200

City/State/Zip: _____

Fort Worth, TX 76102

Contact Person: _____

Fax 817 877-1003 Phone 817 335-3400

Industry Description: _____

Att: _____

Does your Company Carry Worker's Compensation? _____

	Last Name	Age	Sex	Status	Zip	Salary		Last Name	Age	Sex	Status	Zip	Salary
1							26						
2							27						
3							28						
4							29						
5							30						
6							31						
7							32						
8							33						
9							34						
10							35						
11							36						
12							37						
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14							39						
15							40						
16							41						
17							42						
18							43						
19							44						
20							45						
21							46						
22							47						
23							48						
24							49						
25							50						

Status: EE (Employee Only), ES (Employee & Spouse), EC (Employee & Children), FF (Full Family)

Note: Complete Salary for Disability Quotation

Group Health Insurance

Information Required for Premium estimate

Date: _____	Health _____
By: _____	Dental _____

Please include the following for a quote:

Current Census (include dates of birth if possible)

Plan Design (attach benefits booklet)

Major claims/Conditions or printed loss statement

(List conditions by employee)

Employer Contribution 50% 75% 100% Flat Amount \$ _____

Current rates and/or renewal rates

List important Drs. & Hospitals