
**Group Plan Request**

Email or Fax Completed Form

info@michellecrawfordbenefits.com

Fax: 706-568-9979

Group Name: _____

Group Address: _____ City: _____ State: _____ Zip: _____

Effective Date: _____ Business Description: _____

**Please make sure to include everyone including dependents full names, birthdates and home zip to ensure a complete and timely quote.**

**List employees above their dependents. Coverage type definitions to include:**

EMP: Employee Only

ECH: Employee and Children

ESP: Employee and Spouse

FAM: Family

W: Waived

| Last Name | First Name | Birthdate | Gender | Relationship | Home Zip | Medical Coverage Type | Dental Coverage Type | Vision Coverage Type | Life & Disability Coverage Type | Salary Needed for Life & Disability |
|---|---|---|---|---|---|---|---|---|---|---|
| Smith | Joe | 00/00/0000 | M | Employee | 00000 | ESP | EMP | EMP | EMP | $0000000 |
| Smith | Jane | 00/00/0000 | F | Spouse | 00000 | ESP | W | W | W | |
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