

SYNDICATED INSURANCE

..... S E R V I C E S , I N C

-PROPOSAL REQUEST FORM-

Today's Date:	Requested Effective Date:
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BUSINESS INFORMATION

Business Name:	
Partnership: Yes or No?	
Business Street Address, City and Zip Code:	
Business County:	Business Phone Number:

Number of Non-Owner W-2 Employees:	Number of Employees:
Business Start Up Date:	Nature of Business:
Total Number of Employees (include ALL FT/PT/Union/Seasonal):	

CURRENT PLAN INFORMATION

Current Carrier:	Renewal Date:
Current Deductible:	Current Out of Pocket:

CENSUS INFORMATION

	Name (Optional)	DOB	Spouse's DOB	Child(ren)'s DOB	State
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

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