



MORSE INSURANCE AGENCY

sales@morseinsuranceagency.com

**Small Group Benefits Quote Request Form** (< 100 full time equivalent employees)

Business Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Business ZIP Code: \_\_\_\_\_

Industry: \_\_\_\_\_

Number of Full-Time Employees: \_\_\_\_\_

Number of Part-Time Employees: \_\_\_\_\_

Current Insurance Carrier(s): \_\_\_\_\_

Current Renewal Month(s): \_\_\_\_\_

Coverage Interests: Medical [ ] Dental [ ] Vision [ ] Life [ ] Disability [ ]

Additional Notes:

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