Infinitus Quote Request Form

*Please remit prior carriers benefits schedule if you need to match benefits for this quote



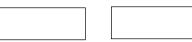
		Broker Reque	sting Quo	ote			
Name				Phone			
Street Address							
City		State		Zip Code			
Email				•			
Broker Code	Date Q Neede			Effective Date			
		Group Info	rmation				
Group Name							
Group Street Address							
City		State		Zip			
Group SIC	# FT Employees			# Employees on Cobra			
		nes to Quote (check urrent or renewal rates at			ed)		
Dental	Vision	Life	STD		LTD	Accident	
Critical Illness	Cancer	LTC	Hosp.	Indemnity	Teladoc	HSA	
Payroll	Pre-Need	Final Expense	Legal		Pet	FSA	
Medical	Fully Insured	Level-Funded	Self-Funded		GAP	Stop-Loss	
Medicare	MEC	ACA	RBP		Short term Med	HR	

Please fill out the following pages and describe the groups current benefits (if any) and who is paying the premium. Also, please include current or renewal rates, and current benefit plans so that we can match benefits accordingly. Please included a current employee census that includes, name, DOB, sex, full-time, part-time, cobra. For disability quotes, please include salary and occupation. On the next pages in the detail box, please explain all the details of the benefits you need quoted.

(IE... co-pays, benefits, maximums, elimination periods, benefit durations etc.)

Send Quotes To: ron@theinfinitus.com

You can also submit this quote by using the interactive email link below.



Medical	Current Car	rier			Employer Paid	Yes	No	ER%	
Plans to Quote	НМО	PPO	MEC	ACA	Self-Funded	Other	•		
Benefits to Quote:									
Dental	Current Car	rier			Employer Paid	Yes	No	ER%	
Plans to Quote	НМО	PPO	Indemnity		DMO				
Benefits to Quote:									
Vision	Current Car	rier			Employer Paid	Yes	No	ER%	
Plans to Quote	Fully Insured		ount Plan			105	110	211/0	
Life	Current Car	rier			Employer Paid	Yes	No	ER%	
Plans to Quote	Basic	Voluntary							
Benefits to Quote:					T	Ň		550/	
STD	Current Car				Employer Paid	Yes	No	ER%	
Plans to Quote Benefits to Quote:	Elimination Da	ys Acc	Illness	% Amo	ount Max \$		Duration – 2	2yr 5yr	SSNRA

TD	Current Carrier			Employer Paid	Yes	No	ER%
Plans to Quote	Elimination Days	90	180	% of Monthly Salary	Max	Monthly \$	
senefits to Quote:							
	Current Carrier			Employer Paid	Yes	No	ER%
Plans to Quote					105	110	Litt
Benefits to Quote:							
	Γ			1			
	Current Carrier			Employer Paid	Yes	No	ER%
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Benefits to Quote:							
	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote:	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote	Current Carrier			Employer Paid	Yes	No	ER%
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Benefits to Quote: Plans to Quote Benefits to Quote:	Current Carrier			Employer Paid	Yes	No	ER%
Benefits to Quote: Plans to Quote Benefits to Quote: Plans to Quote							
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