Infinitus Quote Request Form

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

Broker Requesting Quote					
Name				Phone	
Street Address					
City		State		Zip Code	
Email					
Broker Code	Date Quote Needed			Effective Date	

Group Information					
Group Name					
Group Street Address					
City		State		Zip	
Group SIC	# FT Employees			# Employees on Cobra	

Business Lines to Quote (check each that is requested)

Provide current or renewal rates at the bottom of this form

☐ 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.

QRFAL2023

Email Form

Print Form

Medical	**Current Carrier**				**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**HMO** ☐	**PPO** ☐	**MEC** ☐	**ACA** ☐	**Self-Funded** ☐ **Other** ☐
Benefits to Quote:					

Dental	**Current Carrier**			**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**HMO** ☐	**PPO** ☐	**Indemnity** ☐	☐ **DMO**
Benefits to Quote:				

Vision	**Current Carrier**		**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**Fully Insured** ☐	**Discount Plan** ☐	
Benefits to Quote:			

Life	**Current Carrier**		**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**Basic** ☐	**Voluntary** ☐	
Benefits to Quote:			

STD	**Current Carrier**			**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**Elimination Days** **Acc** **Illness**	**% Amount** **Max $**		**Duration – 2yr** ☐ **5yr** ☐ **SSNRA** ☐
Benefits to Quote:				

Fill in the benefits you need quoted in the blank boxes below if not previously listed.

LTD	**Current Carrier**	**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote	**Elimination Days** ☐ **90** ☐ **180**	**% of Monthly Salary** **Max Monthly $**
Benefits to Quote:		
	Current Carrier	**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote		
Benefits to Quote:		
	Current Carrier	**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote		
Benefits to Quote:		
	Current Carrier	**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote		
Benefits to Quote:		
	Current Carrier	**Employer Paid** ☐ Yes ☐ No ER%
Plans to Quote		
Benefits to Quote:		