

Agent / Broker:	
Phone #	-
Email:	-



Health Quote Request

Phone (316)712-5093

Fax(316)440-4046

Email info@richeyhealthbenefits.com

Company	Phon	e		
Address	₋ Fax			
City, State, Zip	_ Company C	ontact		
Type of Business	Email			
Number of eligible employees	Requested Effe	ective Date		
Number of enrolled employees	Please attach census (template on back)			
Current Health Carrier ☐ Aetna ☐ Blue Cross ☐ United Healthcare ☐ Other ☐ None	-	Renewal Date		
Current Dental Carrier	□ None	Renewal Date		
Current Vision Carrier	□ None	Renewal Date		
Voluntary Benefits Carrier				
□Aflac □ Allstate □ Colonial □Other	□ None	Renewal Date		
Basic Life & AD&D Carrier	□ None	Renewal Date		
Short-term Disability / Long-term Disability Carrier	_ □ None	Renewal Date		
Section 125 Plan Administrator	□ None	Renewal Date		
□POP □ FSA □DSA				

CENSUS FORM

Company Name:			<u> </u>					
Company Address:								
City, State, Zip:			Waiting Period: Total Eligible:					
Company Contact:								
Effective Date: Enrolled:								
E=Employee S=Spouse C=Child	Last Name	First Name	Date of Birth	Gender	Zip Code	Enrollment Tier E= Single ES=Employee + Spouse EC=Employee + Children F=Family W=Waiver		
Е	Example	Joe	mm/dd/yyyy	M	67207	Е		
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