

Large Group Employer Quote Request Form

To assist us in providing you a group health insurance quote, please print this form, complete the following information, and return by fax to (732)842-6421.

It is not required to complete all entries.

If you need assistance completing information or would like a representative to complete the form with you, please email us at NJGroupHealth.com include your name, telephone number, and a convenient time to call.

If you would like immediate assistance please contact us by phone (732)842-7445.

Company Name: _____ Company Contact Name: _____
Company Owner's Name: _____ Title: _____
Email: _____

Home Office Address Mailing Address
Street: _____ Street: _____

County: _____ PO Box: _____
City: _____ City: _____
State: NJ Zip Code: _____ - State: NJ Zip Code: _____ -

Phone Number: (____) _____ Fax Number: (____) _____

Business Entity. Corp: ___ Sub S: ___ LLC: ___ Prtnshp: ___ Other: ___ SIC Code: ___

Nature of Business: _____

Total # of Full Time (25 hrs+) Employees: _____

How Long in Business: _____

Amount of Employer Contribution to Plan: _____%

Name of Current Group Health Coverage (if any): _____

List Subgroup Health Coverage (if any): _____

Actual effective date of current plan: ____/____/____

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If you are requesting a quote to compare with your current plan, please include a "Summary of Benefits". Otherwise, select the following benefit options.

Plan Type - POS ____, O/A POS ____, PPO ____, HMO ____, O/A HMO ____

Self Funding ____, IND ____, NGP ____

In-Network: Co-Pay \$____ Hospital Co-Pay/Deductible \$____, RX card \$____ Deductible \$____

Out-Of-Network: Deductible ____, Co-Insurance ____%

Select the ancillary benefits you wish to have quoted or submit a current plan "Summary of Benefits".

Voluntary Benefit Selections:

Dental ____, Life ____, LTD ____, STD ____, Vision ____

Employer Paid benefit Selection:

Dental ____, Life ____, LTD ____, STD ____, Vision ____

Check List

Before faxing us your request, please review the following check list to assure we will have the required information to properly quote your group benefits.

(1). A Completed "Small Group Employer" Quote Request Form.

(2). A Completed "Employee Census Form."

(3). A "Summary of Benefits" form for all requested quotes.

Medical # Dental # Life #LTD # STD # Vision

In addition to the above information we will require an employee census form. You may use your own form if it provides the following employee information; Name, Gender, Date of Birth, Family Status, and Waiver information. If you do not have a detailed form, please download one of our census forms. Please print the census form, complete, and return form together with this request.