

# Small Group Employer Quote Request Form

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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): \_\_\_\_\_

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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 \_\_\_\_, 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.