TripleChoicePlan

CHECKLIST - "REQUEST FOR QUOTE" (RFQ)

Employer Information:

Legal Name _____
DBA Name _____
Address _____
City _____ State _____ Zip _____

Number of Full-Time Employees _____
Number of Eligible Employees _____

Number of Locations: In-state _____ Out-of-state _____
Nature of Business _____ **SIC CODE** _____

Requested Plan Effective Date: _____ **Current Carrier** _____
Contributions: Voluntary _____ Employer pay _____
Dental % _____ or $ _____
Life % _____ or $ _____

Participation Assumed: _____

Special Request: _____

Broker Representative: _____

Broker Information:

Name/Title _____ **Agency/Agent Lic. #** _____ **Firm** _____
Address _____
City _____ **State** _____ **Zip** _____
Phone _____ **Fax** _____ **e-Mail** _____
Broker of Record **Yes** _____ **No** _____

Dental:

- Employee's Name
- Employee's Dependent Status
- Current Plan - PPO or DHMO

Life:

Employee's Name
Employee's Date of Birth or Age
Gender
For Male = M
For Female = F
Job Descriptions, i.e., Owner/Officer
Managers

Please e-mail to: LA.quotes@TripleChoicePlan.com

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