

Group Proposal Request Form



Business Name: _____
City: _____ State: _____ Zip Code: _____
Nature of Business: _____ SIC Code: _____
Tax Filing Classification: S-Corp C-Corp Other (please list): _____
Requested Effective Date: _____ Need Quote By: _____
Total Full-time Employees: _____ Total # of Covered Employees: _____
Agent Name: _____ Agent Phone: _____
Agent E-mail: _____ Agent Fax: _____
Is Quoting Agent the Current Agent of Record? Yes No
Special Requests: _____

- Current Census*
- Current Carrier Name*
- Current and Renewal Rates*
- Current Schedule of Benefits*
- Employer Contribution* Employee: _____ Dependent: _____
- Anniversary Date*: _____
- Is Claims Experience Available? Yes No
 - Yes No AIDS or an AIDS-related complex or other immune system disorder.
 - Yes No Disease of the brain, nervous system or any congenital disease or disorder.
 - Yes No Cancer or cancerous tumor.
 - Yes No Heart or vascular disease, or stroke.
 - Yes No Diabetes or any disease or disorder of the kidneys, liver or lungs.
 - Yes No Organ or bone marrow transplant.

*** A quote cannot be released without these requirements.**

Affiliates: Yes No If Yes, is it the same industry? (Please provide details if not):

List additional locations/affiliates along with number of employees at each location (include county & state):

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