

Request for Quote Form  
Employee Benefits



Name of Business: \_\_\_\_\_

Check one: Corporation  LLC  Partnership

Individual / Sole Proprietor  Other

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Website: \_\_\_\_\_

Description of Operations \_\_\_\_\_

List States in which the entity operates: \_\_\_\_\_

Years in Operation: \_\_\_\_\_

Do you currently have Dental Insurance: Yes  No

If yes : Current Company \_\_\_\_\_

Expiration Date of Policy: \_\_\_\_\_

Do you currently have Medical Insurance: Yes  No

If yes : Current Company \_\_\_\_\_

Expiration Date of Policy: \_\_\_\_\_

Do you currently have Life and Disability Insurance: Yes  No

If yes : Current Company \_\_\_\_\_

Expiration Date of Policy: \_\_\_\_\_

Interested in Quotes For: Group Medical Yes  No

Life Yes  No  Dental Yes  No  Disability Income Yes  No

Vision Yes  No

Please E-Mail this back to [twelden@eatonberube.com](mailto:twelden@eatonberube.com) or Fax to 673-7458 so that we can contact you about providing quotes that will best fit your business.