Association Insurance Program
Group Health Quote Worksheet

Association Name: _____

Group/Organization Name: _____

Contact Person:_____

Telephone:_____ Fax:_____ E-mail:_____

Nature of Industry: _____

Address:_____

City:_____State:_____Postal Code:_____

Requested Effective Date: _____

Total number of full-time employees:_____ Total number of full-time employees to be insured:_____

Does your organization currently have group medical insurance? ☐ Yes ☐ No

(If yes, please provide name of carrier, current and renewal rates, schedule of benefits, and claims experience if available.)_____

REQUESTED PLAN OF BENEFITS

Deductible
- ☐ $0
- ☐ $100
- ☐ $200
- ☐ $250
- ☐ $500
- ☐ $1,000
- ☐ $2,500
- ☐ $5,000
- ☐ $10,000
- ☐ $_____

HSA / HRA
- ☐ HSA
- ☐ HRA

Disability
- ☐ Long-Term
- ☐ Short-Term

Life Insurance Benefit*
- ☐ $10,000
- ☐ $15,000
- ☐ $25,000
- ☐ $50,000
- ☐ 1 X's Salary to a Maximum of $_____
- ☐ 2 X's Salary to a Maximum of $_____
- ☐ Other

- ☐ Dental
- ☐ Vision

Other Coverage's
(please specify your needs)

EMPLOYEE CENSUS (Required to quote group medical, dental, life, disability)

***Coverage needed: You can attach a separate census or additional pages as necessary**

EE = Employee Only; EE + CH = Employee + All Children; EE + SP = Employee + Spouse; EE + Family = Employee + Spouse and child(ren)

Gender	**Employee Name (optional)** (indicate if COBRA employee)	**Coverage needed***	**Age or Date of Birth**	**Annual Salary** (required for disability and/or salary-based life insurance	**Age of Spouse** (if known)	**Total number of children** (if known)	**Ages of Children (if known)**
Male	*(Sample) John Doe*	*EE + Family*	*45*	*$75,000*	*41*	*3*	*6, 10, 13*

Please complete this form and return via email, fax or mail: **Michael George @ AMJ Insurance, Inc.**
7150 Winton Drive, Suite 300, Indianapolis, Indiana 46268
Toll Free: 888.258.6820 *ext.172* Direct Ph & Fx: 317.735.4072 mgeorge@amj-ins.com

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