LBS Insurance Group

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Group Health Insurance Insurance Quote Form

You may complete this form and send it to us using our secure server by clicking on the "Submit" button below or you may fill in the information, print the form from your browser window by clicking "Print Page" button above and mail or fax the form to:

LBS Insurance Group
303 West Main Street
P.O. Box 498
Ashland, WI 54806-0498
Phone: 715-682-6197
Fax: 715-682-6312
www.lbsinsurancegroup.com

* Denotes Required Field

General Information

***Legal Name of Business:**

***Contact Name:**

***Address:**

***City:** ***State:** Select One ***Zip Code:**

***Business Phone:** ***Fax:** *Ex. 920-111-2222*

Best Time to Call: Select One

***E-Mail Address:**

***Confirm E-Mail Address:**

Type of Business

Type of Business:

Standard Industry Code (if known) :

# of Full-Time Employees: **# of Part-Time Employees:**

Give a complete description of any type of hazardous/dangerous duties performed by your employees:

Current Group Health Insurance Information

Company Name *(not agency)*:

Policy Expiration Date: *Ex. 01/15/2007*

Premium Amount: $

Please give a brief description of your current Group Health plan:

Benefits Desired

Major Medical Deductible:	Select One	**Optional Pregnancy Coverage:**	Select One
Dental Coverage:	Select One	**Supplemental Accident Coverage:**	Select One
Disability Insurance:	Select One	**PCS Card** *(Prescription Discount Option):*	Select One
Group Life Insurance:	Select One	**PPO Option:**	Select One
Amount: $		**HMO Option:**	Select One

Employee Information

If you have your census in Microsoft Excel format, please send it as an e-mail attachment to our company at: cquotes@lbsinsurancegroup.com.

The census is not required to be completed prior to sending it to our company.

Please list all employees you wish to cover

Employee Name	Date of Birth *Ex. 01/15/2004*	Age	Sex	Dependent Status
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One
			Select One	Select One

If you were not able to list all employees you wish to cover in the spaces above, please use the Additional Comments section below OR indicate that you will fax or e-mail an additional listing.

Additional Comments

Please provide any additional comments that you feel would be appropriate for this quotation. If you have additional information to provide, where there were not enough fields above, please enter it here:

*Acknowledgement and Consent

I hereby certify that the above information is complete and accurate to the best of my knowledge. The agency receiving this application will retain the application whether or not a policy is issued. The agency may rely on this application when determining the quotation and when deciding whether to issue a policy. False statements may subject me to criminal penalties.

If a policy is issued, I authorize the agency to give information about me to its affiliates. ○ **Yes** ○ **No**

***Enter Your Initials Here:** _____ ***Today's Date:** _____ *EX: 01/12/2007*

View our Privacy Policy

Submit **Reset**