

GROUP INSURANCE QUOTE FORM

DATE: _____

COMPANY: _____

CONTACT NAME: _____ Email: _____

ADDRESS: _____

CITY/TOWN: _____ PROVINCE: _____ POSTAL CODE: _____

TELEPHONE: _____ FAX NO.: _____

1. # Full-time Employees: _____ # Part-time Employees: _____

(NOTE: **Full-time** employees must work two thirds of the firm's normal hours but not less than twenty (20) hours per week.)

2. Does your company currently have an employee group benefits plan in place? YES NO

3. Is your company a member of a Chamber of Commerce/Board of Trade? YES NO

4. Which insurance carrier currently provides your employee benefits? _____

5. When does your policy renew? DATE: _____

5. Do you wish to retain the same levels of coverage? YES NO

7. How long has your company been in active operation? _____ years _____ months

8. If your business is seasonal, it is in operation for _____ months of each year.

9. Briefly describe the type of business your company engages in:

10. Is your company a: Sole proprietorship Partnership Corporation

11. Do any of the employees currently suffer from any illness or medical condition

12. Where did you hear about the Chamber Plan and/or Doucett Insurance? Direct Mail Brochure Fax

Email Referred by: _____ Chamber of Commerce Referred by: _____

Other Explain: _____

Notes:

Office Use Only – Broker Assigned: _____ Date: _____ Assigned By: _____

