ELAN SOLUTIONS, INC.

QUOTE REQUEST FORM

Please complete the information accurately

I. General information

1) **Effective Date Requested** _____

2) **Company Name:** _____

3) **Address:** _____

4) **Group Financial Contact Name:** _____**E-mail address:** _____

Phone: _____

5) **Group Administrator Contact Name:** _____**Title:** _____

6) **Phone:** _____ **E-mail address:** _____

II. Group information

1) **Total No. of Eligible Employees:** _____

2) **Employer contributions**: ☐ 50% ☐ 75% ☐ 100% ☐ Other _____

3) **Do you have existing coverage?** ☐ Yes ☐ No

Please include the following

☐ Census – a list of all insureds – including dependents to be covered – with their age or date of birth.

☐ Copy of your most recent medical insurance billing statement.

☐ Copy of your Renewal page (last year's or upcoming if available) – so we may match your current benefits.

III. Requested Plans, Benefits and Programs

Please Choose the Plans to Highlight in the Proposal:

Medical and Pharmacy	Groups without current coverage	Groups with 2-3 Eligible Employees	Groups 4-10 Eligible Employees	Groups 11 or more Eligible Employees
Option 1	SELECT PLAN	SELECT PLAN	SELECT PLAN	SELECT PLAN
Option 2	SELECT PLAN	SELECT PLAN	SELECT PLAN	SELECT PLAN
Option 3	SELECT PLAN	SELECT PLAN	SELECT PLAN	SELECT PLAN
Rating Method	Age-banded rates	Age-banded rates	Age-banded rates or Composite Rates	Composite Rates
Enhanced Dental	Included	Included	Optional	Optional
Enhanced Vision	Included	Included	Optional	Optional

Please Choose the Additional Benefits and Programs:

☐ Enhanced Dental	☐ Voluntary Dental (No Ortho)	☐ Enhanced Vision	☐ HRA Administration
☐ COBRA Administration	☐ Employee Assistance Program (EAP)	☐ Life Insurance	
Domestic Partners — ☑ Yes			

Thank you. We will have a proposal ready within two (2) business days of your submission. For questions, please contact your insurance agent or ELAN at sales@elan.agency