



# QUICK QUOTE

## Group Benefits

Page 1

Date: \_\_\_\_\_

Company Name

Contact Person

\_\_\_\_\_

\_\_\_\_\_

Company Address

City

State

Zip

\_\_\_\_\_

Company Phone Number

Company Fax Number

E-Mail Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type of Industry

Requested Effective Date

Hospital Preference

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Renewal Date

Current Carrier

\_\_\_\_\_

\_\_\_\_\_

**Employer Contribution:**

Employee

Dependent

\_\_\_\_\_

\_\_\_\_\_

**Please attach an outline of your current benefits.**

**Additional Comments**

Form Continued on Page 2

Please print this form and fax to MSMA Insurance Agency (573) 634-4062



**Coverage Codes:** EE= Employee, ES= Employee & Spouse, EC= Employee & Children, F= Family

Employee Name	Sex M / F	Employee D.O.B.	Coverage (EE, ES, EC, F)	Spouse DOB	Number of Children	Monthly Salary