BUA Group Health Insurance Quote Request

Please complete and Fax back to BUA at 330-929-9994

Agent Name: _____ Phone _____

Group Name:
Group Address:
Nature of Business:

Employee Participation

Full Time
Part Time
COBRA
Total

Group Background Information

1	Are you the group's current Agent?	
2	Does this group have current coverage?	
3	Who are they currently With?	
4	What is their current premium?	
5	When is their renewal?	
6	What is their renewal premium?	
7	Do they offer a Section 125 Plan?	
8	Do they have a COBRA administrator?	
9	Does this group offer voluntary benefits?	

Plan Design Options

Plan Type
Deductible
Coinsurance
Coinsurance Limit
Maternity
Prescription Drug
Life
Dental
Vision

	Employee Name	Sex	Age/DOB	EE	ES	EC	FF	LO	W	Number of Children	Employee Class	Salary	Occupation	Medical Conditions
1														
2														
3														
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