

PITTSBURGH BENEFITS GROUP, INC.

FOUR GATEWAY CENTER, SUITE 605
PITTSBURGH, PA 15222
(412) 338-9800 ext. 6070

(or)

109 N. FAIRFIELD ST.
PO BOX 946
LIGONIER, PA 15658-0946
(724)238-6886 voice
(724)238-6223 fax

GROUP BENEFITS QUOTE REQUEST

Agent(s):

Original Appointment Date: _____ **Follow-up Appointment Date (if scheduled):** _____

I. Client Profile

- ___ Legal Name
- ___ Address
- ___ County
- ___ Phone/Fax #
- ___ Contact Name
- ___ Nature of Business/SIC Code
- ___ Workers Compensation Carrier (required for UPMC quote)
- ___ Current Census – See Attached *Employee Census Information* Form
- ___ Copy of Most Recent Form UC-2 (PA State Unemployment Tax Form)
- ___ Please indicate which employees are ineligible and reason (ie. Part-time, covered under spouse, etc.)
- ___ Waiting period for new hires
- ___ Employee Contribution %
- ___ Sect. 125 (Employee contributions on “pre-tax basis”?)

For groups of 50 or more employees

- ___ Claims experience for prior two years (if available)
- ___ Details of claims in excess of \$25,000 in past 12 months (diagnosis, prognosis, \$ amount)

II. CURRENT COVERAGES*

- ___ **Life & AD&D** Rate: _____
Amount: _____
- ___ **Dependent Life** Rate: _____
Amount: _____
- ___ **Short Term Disability (STD)** Rate: _____
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
- ___ **Long Term Disability (LTD)** Rate: _____
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
- ___ **Vision** Rate: _____
Deductible: _____
Benefit Amounts: _____
- ___ **Dental** Rate: _____
Deductible: _____
Benefit Amounts: _____
- ___ **Medical** Rates: _____
Plan Type (PPO, HMO, etc.): _____
Physician Office Copay: _____
Deductible: _____
Coinsurance: _____

III. QUOTES REQUESTED

- ___ **Life & AD&D**
Amount: _____
- ___ **Dependent Life**
Amount: _____
- ___ **Short Term Disability (STD)**
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
- ___ **Long Term Disability (LTD)**
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
- ___ **Vision**
Deductible: _____
Benefit Amount: _____
- ___ **Dental**
Deductible: _____
Benefit Amounts: _____
- ___ **Medical**
Plan Type: _____
Physician Office Copay: _____
Deductible: _____
Coinsurance: _____

*In lieu of completing the “Current Coverages” information, a copy of the current carrier’s most recent invoice and benefits booklet can be submitted.

Employee Census Information

Business Name _____

Business Address _____

Agent Name(s) _____

Name	Sex	Date of Birth	Date of Hire	Dependent Status*	Home Zip Code	Occupation <i>Required for Disability Quotes</i>	Annual Income <i>Required for Disability Quotes</i>
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

*E=Employee Only, SP=Employee & Spouse, PC=Employee & Child(ren), F=Family