REZA SHAH
FINANCIAL & INSURANCE SERVICES, INC.

Group Health Ins. Quote Form

Phone: 949 305-2300 | 949 877- REZA | Fax: 949 872-2301 | reza@rezashahinsurance.com | CA Lic. # 0C52065

A Broker Information

AGENT NAME _____

☐ CHECK IF NEW ADDRESS

BROKER CODE (IF KNOWN) _____

AGENCY Reza Shah Financial & Insurance Srvcs, Inc.

ADDRESS 4000 MacArthur Blvd Ste. 600 East Tower

CITY Newport Beach, CA ZIP 92660

PHONE (949) 305-2300 FAX (949) 872-2301

DELIVERY OF PROPOSAL:

☐ INITIAL ☐ MINI

☐ WILL PICK UP

☐ MAIL COMPLETE PROPOSAL

☐ HAVE REPRESENTATIVE CALL

☑ EMAIL COMPLETE PROPOSAL TO:

reza@rezashahinsurance.com

FAX COMPLETED FORM TO (949) 872-2301

B Group Information

COMPANY NAME _____

STREET ADDRESS _____
(NO P.O. BOX)

CITY _____, CA ZIP _____

1. NATURE OF BUSINESS _____ → SIC CODE

2. LEGAL STRUCTURE OF THE BUSINESS:
   ☐ CORPORATION ☐ PARTNERSHIP ☐ S CORPORATION
   ☐ SOLE PROPRIETOR ☐ OTHER _____

3. CURRENT MEDICAL CARRIER _____
   CURRENT MONTHLY PREMIUM _____
   PLAN TYPE: ☐ HMO ☐ PPO ☐ MULTI/OPTION

4. DOES GROUP CURRENTLY HAVE A DENTAL PLAN ? ☐ YES ☐ NO
   NAME OF DENTAL CARRIER _____

5. REQUESTED EFFECTIVE DATE _____

6. # OF ELIGIBLE EMPLOYEES _____

7. # OF PART-TIME EMPLOYEES _____

ELIGIBILITY REQUIREMENTS:
SEE UNDERWRITING GUIDELINES FOR DETAILS.

8. OUT-OF-STATE EMPLOYEES? ☐ YES ☐ NO
   (IF YES, PLEASE COMPLETE OUT-OF-STATE CENSUS ON BACK)

9. % OF COSTS TO BE PAID BY EMPLOYER:
   _____% EMPLOYEE COSTS
   _____% DEPENDENT COSTS

EMPLOYER MUST CONTRIBUTE A MINIMUM OF 50% OF THE LOWEST COST EMPLOYEE PREMIUM AVAILABLE

C Life Insurance Enrollment Information

Choose one of two methods below

Coverage limits available for both methods	ELIGIBLE EMPLOYEES	GUARANTEED ISSUE MINIMUM	GUARANTEED ISSUE MAXIMUM
	1-10	$10,000	$25,000
	11-25	$10,000	$50,000
	26-50	$10,000	$75,000

METHOD 1:

EMPLOYER MAY SELECT A FLAT AMOUNT OF INSURANCE STARTING AT $10,000 AND INCREASING BY INCREMENTS OF $5,000 TO THE MAXIMUM AMOUNT ALLOWED FOR THE NUMBER OF ELIGIBLE EMPLOYEES (SEE CHART). INDICATE NUMBER OF ELIGIBLE EMPLOYEES AND FLAT AMOUNT BELOW:

OF ELIGIBLE EMPLOYEES: _____ FLAT AMOUNT: _____

To obtain life coverage, ALL full time employees enrolling in or waiving medical must be covered

METHOD 2:

EMPLOYER MAY SELECT UP TO 4 CLASSIFICATIONS OF INSURANCE COVERAGE IN $5,000 INCREMENTS, WITH THE HIGHEST AMOUNT NO MORE THAN 2.5 TIMES THE LOWEST AMOUNT SELECTED:

LOWEST AMOUNT: $ *$5,000 INCREMENTS ONLY* **X 2.5 =** HIGHEST AMOUNT: $ *$500 INCREMENTS O.K.*

PLEASE ENTER UP TO 4 LIFE COVERAGE AMOUNTS THAT INCLUDE AND/OR FALL WITHIN THE MINIMUM AND MAXIMUM AMOUNTS ABOVE & EMPLOYEE CLASSIFICATION (i.e. EXECUTIVE, MANAGEMENT, HOURLY, ETC.) FOR EACH:

LIFE AMOUNT	*EMPLOYEE CLASSIFICATION LEVEL TO BE OFFERED THIS AMOUNT*
$	
$	
$	
$	

See other side for census information

D Census Information

	Employee (EE) Name *Last, First*	EE Date of Birth (Mo/Day/Yr)	EE Home ZIP Code/ County	EE Gender (M/F)	✓ If on COBRA	DEPENDENTS				Life Amount $
						Spouse	Children Aged 0-18	Children Aged 19-25		
						Date of Birth Mo/Day/Yr	Number of Children	Date of Birth of Each Child	Disabled? Yes/No	
1					☐					
2					☐					
3					☐					
4					☐					
5					☐					
6					☐					
7					☐					
8					☐					
9					☐					
10					☐					

E Out-of-State Census Information

	Employee (EE) Name *Last, First*	EE Date of Birth (Mo/Day/Yr)	EE Home ZIP Code/ County	EE Gender (M/F)	✓ If on COBRA	DEPENDENTS				Life Amount $
						Spouse	Children Aged 0-18	Children Aged 19-25		
						Date of Birth Mo/Day/Yr	Number of Children	Date of Birth of Each Child	Disabled? Yes/No	
1					☐					
2					☐					
3					☐					
4					☐					