

# BDG

**the Benefits Design Group, LLC**

## Request a Quote

For Individual (&/or Family)

Complete and return to BDG by fax or mail.

Your information will be kept confidential.

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Type of coverage desired:

Life Insurance (Benefit amount desired: \$ \_\_\_\_\_) Next, complete census information below and state the reason for the coverage in the comments section at the bottom (i.e. family protection, business)

Disability Insurance (Monthly benefit amount desired: \$ \_\_\_\_\_) Next, complete census information below and state reason for the coverage in the comments section (i.e. income replacement, business overhead expense)

Long Term Care Insurance (Monthly benefit amount desired: \$ \_\_\_\_\_) Complete census info

Health Insurance. Please complete all information below.

Do you need coverage for more than 6 months? Yes No

Are you COBRA eligible? Yes No

If yes, eligibility start date: \_\_\_\_\_ eligibility end date: \_\_\_\_\_

Current Medical Carrier: \_\_\_\_\_ PPO/POS/HMO? \_\_\_\_\_

Deductible: \_\_\_\_\_ Office Visit Copay: \_\_\_\_\_ Prescription Copay: \_\_\_\_\_

Coinsurance% after Deductible: \_\_\_\_\_ Out of Pocket Maximum: \$ \_\_\_\_\_ Monthly Premium: \_\_\_\_\_

**Census Information:** (Yourself and any dependents to be covered)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Smoker: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

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Medical Conditions/Prescriptions: \_\_\_\_\_

Comments: \_\_\_\_\_