

Fax or Mail back to:

Syndicated Insurance Services
1305 Wiley Rd., Suite 132
Schaumburg, IL 60173
Toll Free Fax (888) 232-9747 Toll Free Phone (888) 287-3747

Group Quote

Date: _____

Broker: _____

Fax #: _____ Phone #: _____

Group Name: _____ Current Carrier: _____

City: _____ State: ____ Zip Code: _____ Effective Date: _____

Nature of Business/SIC Code: _____

Desired Network(s): _____

Deductible:		Co-Pay or In/Out-Network:		Drug Card Deductible:	Coinsurance:	
\$0/\$250	\$1000	\$10	10/30	10/20-200 Ded.	100/70	80/70
\$0/\$500	\$1500	\$15	15/35	10/20-300 Ded.	90/80	80/60
\$150	\$2500	\$20	20/40	10/20/40or30%-No Ded.	90/70	70/60
\$250	\$5000	\$25	25/45	Best Card w/ No Ded.	90/60	70/50
\$500	\$10,000	\$30			90/50	60/50
\$750		\$40				

Stoploss Amount:	Supplemental Accident:	Life Amount:
\$2500	\$300	Class 1: _____
\$5000	\$500	Class 2: _____
\$10,000	\$1,000	Class 3: _____
\$15,000		

Maternity: Y or N

Preventive Care: Y or N

Life Choice: None Lowest 1 x salary 2 x salary 3 x salary Life Only

STD: Y or N

Not to Exceed: _____

Duration: 1/8/13 1/8/26 1/8/52

LTD: Y or N

Elimination Period: 90 day 180 day Benefit Amount Not to Exceed: _____

Dental: Y or N

Maximum Benefit: \$1000 \$1500

Vision (Not Standalone): Y or N

