BENECON
Ancillary Benefits

Quote Request Form

Include the following information:

*Census (Excel Format) Name, Gender, DOB, Occupation & Wage Info
**If benefits are by class be sure to identify on census
* Copy of current benefits/schedule of benefits
* Copy of most recent invoice
* Renewal Rates
* Claims Experience: 100+ Lives - STD 500+ Lives - Basic Life and LTD

Your Agency Name:
Contact Name:
Phone Number:

Group Name:
Group Address:
SIC Code:
Number of Eligible Lives:
Current Carrier:
Current Broker:
Effective Date:
100% Employer Paid?

Life
Benefit Amount:

STD Benefit
Injury/Illness Elim. Period:
Duration: 12 Weeks 26 Weeks 52 Weeks
Salary Percentage: 50% 60% 66.67% 70%
Weekly Maximum Benefit:

LTD Benefit
Elmination Period: 90 Days 180 Days
Salary Percentage: 50% 60% 66.67% 70%
Monthly Maximum Benefit:
Duration: SSNRA Other:

Dental
Deductible:
Orthodontia: YES NO
Type: 100% Employer Paid Voluntary Contributory

Comments:

*Return quote request to: vhenry@benecon.com
sgingrich@benecon.com