



REQUEST FOR CUSTOM GROUP DENTAL QUOTE

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BROKER INFORMATION

DATE:

BROKER NAME		PHONE
AGENCY NAME		FAX NUMBER
ADDRESS		E-MAIL ADDRESS
CITY	STATE	ZIP

PROPOSAL REQUEST

DATE REQUIRED:	EFFECTIVE DATE	
GROUP NAME:		CITY, STATE, ZIP
NATURE OF BUSINESS	SIC CODE	NUMBER OF EMPLOYEES

GROUP DENTAL PLAN DISCRIPTION

PLAN:	CLASS I: %	CLASS II: %	CLASS III: %
DEDUCTIBLE:	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> \$100 Lifetime		CLASS I WAIVED: <input type="checkbox"/> YES <input type="checkbox"/> NO
MAXIMUM:	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000		
ORTHODONTIA:	<input type="checkbox"/> YES <input type="checkbox"/> NO Lifetime Max: \$		
IS TAKEOVER DESIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO		EMPLOYER CONTRIBUTION:
			EE: % DEP: %
	NUMBER	CURRENT RATES	RENEWAL RATES
EE ONLY			
EE + SPOUSE			
EE + CHILDREN			
EE + FAMILY			

CURRENT PLAN	NOTES & COMMENTS
CURRENT CARRIER: DEDUCTIBLE: ANNUAL MAX: COINSURANCE CLASS I - PRENTITIVE: % CLASS II - BASIC: % CLASS III - MAJOR: % CLASS IV - ORTHODONTIA: %	

EXPERIENCE IS REQUIRED FOR ALL CASES WITH OVER 100 LIVES AND EXISTING DENTAL CONVERAGE:
 Experience is attached. Experience will be forwarded ASAP

FOR BETTER QUOTES ON GROUPS OVER 50 LIVES PLEASE ATTACH A CENSUS THAT INCLUDES AGE OR DOB, SEX, AND COVERAGE DESIRED

<input type="checkbox"/> FAX PROPOSAL TO:	<input type="checkbox"/> E-MAIL PROPOSAL TO:
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TOTAL PAGES IN THIS FAX:	
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