Quote Request Form - Email / FAX

To:	**Dan Leavell**	From:
Fax:	**205-409-3306**	Pages:
Phone:	**205-343-1279**	Date:
E-Mail:	**dleavell@southlandbenefit.com**	E-Mail:

Group Name:	**City Located:**	**Zip Code:**	**Estimated Effective Date:**

Describe What Type of Company (SIC CODE):

Products Requested:

- Fully Insured Dental ○
- Fully Insured Vision ○
- Self-Funded Dental ○
- Self-Funded Vision ○

Commission Requested:

Dental Commission (%): _________

Vision Commission (%): _________

*Self-Funded Commission: ____________

*May be based on $ PEPM or % of claims

Contribution:

Employer Pays _________ % for Employee Coverage

Employer Pays _________ % for Dependent Coverage

Participation:

Total Number of Eligible Employees: _________

Assumed EE Participation %: _________

Name of Current Dental Carrier:	**Current Rates:**	**Renewal Rates:**
Name of Current Vision Carrier:	**Current Rates:**	**Renewal Rates:**

Additional Information Requested:

Complete Census – age/date of birth, zip code, gender, coverage election and dependent info (if available)
Current / proposed plan design
Claims' experience (if available)

Notes to Underwriter: