

# Quote Request Form - Email / FAX



To: <b>Nancy Trammell</b>	From:
Fax: <b>205-705-3732</b>	Pages:
Phone: <b>205-343-1280</b>	Date:
E-Mail: <b>ntrammell@southlandbenefit.com</b>	E-Mail:

<b>Group Name:</b>	<b>City Located:</b>	<b>Zip Code:</b>	<b>Estimated Effective Date:</b>
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**Describe What Type of Company (SIC CODE):**

<b>Products Requested:</b> Fully Insured Dental <input type="radio"/> Fully Insured Vision <input type="radio"/> Self-Funded Dental <input type="radio"/> Self-Funded Vision <input type="radio"/>	<b>Commission Requested:</b> Dental Commission (%): _____ Vision Commission (%): _____ *Self-Funded Commission: _____ *May be based on \$ PEPM or % of claims
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<b>Contribution:</b> Employer Pays _____ % for Employee Coverage Employer Pays _____ % for Dependent Coverage	<b>Participation:</b> Total Number of Eligible Employees: _____ Assumed EE Participation %: _____
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<b>Name of Current Dental Carrier:</b>	<b>Current Rates:</b>	<b>Renewal Rates:</b>
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<b>Name of Current Vision Carrier:</b>	<b>Current Rates:</b>	<b>Renewal Rates:</b>
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**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:**