

Group Information

Group Name _____
 Contact Name _____
 Requested Effective Date _____
 Zip _____
 Nature of Business _____
 SIC Code _____
 Current Carrier _____
 Any 1099 Employees? Yes N



Broker/Agency Information

Broker Name Marc Boyajian Insurance Services
 Agency Name _____
 Address 11137 Provence Lane
 City/State/Zip Tujunga
 Phone 818-945-6050 Fax 818-473-4264
 License No 0E13011
 Email marc@simplifiedhealthinsurance.com

Quotes Specifications

Life Amount: _____ (Tip: Leave empty if you do not want Life quoted)
 Employer contribution for employee & dependents EE _____ Dep _____

All Products Listed Below Include AD&D/LTD/STD

Please check all products to be included in your quote.

Carrier	<input type="checkbox"/> All Medical					<input type="checkbox"/> All Dental					<input type="checkbox"/> All Ancillary	
Aetna	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA		<input type="checkbox"/> INDEM	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> FOC			<input type="checkbox"/> Vision	<input type="checkbox"/> Life
Ameritas - Voluntary (NRBT)*						<input type="checkbox"/> PPO						
Anthem Blue Cross	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA			<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	<input type="checkbox"/> Life
Blue Shield	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA			<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	<input type="checkbox"/> Life
CaliforniaChoice	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA	<input type="checkbox"/> EPO		<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> EPO				
Covered CA	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA	<input type="checkbox"/> EPO								
Delta Dental**						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	
Delta Dental - Voluntary (NRBT)****						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO					
Guardian						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO					
Health Net	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA	<input type="checkbox"/> EPO		<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	<input type="checkbox"/> Life
Humana						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	<input type="checkbox"/> Life
Kaiser Permanente	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA			<input type="checkbox"/> PPO	<input type="checkbox"/> HMO		<input type="checkbox"/> INDEM			
MetLife***						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	
Premier Access*****						<input type="checkbox"/> PPO	<input type="checkbox"/> HMO					
Sharp Health Plan		<input type="checkbox"/> HMO	<input type="checkbox"/> HSA									
UnitedHealthcare	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> HSA			<input type="checkbox"/> PPO	<input type="checkbox"/> HMO				<input type="checkbox"/> Vision	<input type="checkbox"/> Life
VSP - Employer Sponsored (NRBT)*****											<input type="checkbox"/> Vision	

VSP - Voluntary (NRBT)*											<input type="checkbox"/> Vision		
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*1 life minimum
 ** 2 lives min. dental, 5 lives min. vision
 ***3 lives min. dental PPO, 5 HMO
 ****3 lives min. PPO, 1 HMO
 ***** 3 lives minimum

Delivery Instructions

Due Date _____

Bind Quote Yes No

Send Via Fax Mail Email Overnight Pickup