Access Benefits Consultant
Quote Request

Agent Name _____

Agency Name _____

Address _____

City, State, Zip _____

Phone _____ Email Address _____

Prospective Client's Name _____
(This is confidential information. NO direct contact will be made by ABC, Inc. &/or affiliates)

City, State, Zip _____

Number of Employees _____ Job Classification/SIC code _____

Benefits Needed for Quote: (Please check all that apply.)

1. ___ **STD: Elimination Period and Benefit duration**
   Elim. Pd: __ 0/7 | __ 7/7 | __ 0/14 | __ 14/14 | __ 30/30 | __ 6-/60 | __ 90/90 | __ Other
   Benefit Duration: ___ 3 mos. | ___ 6 mos. | ___ 12 mos. | ___ 24 mos. | ___ 60 mos.

2. ___ **LTD: Elimination Period and Benefit duration**
   Elim. Pd: ___ 90/90 | ___ 180/180 | ___ Other
   Benefit Duration: ___ 5 years | ___ 65 years

3. ___ **Accident**

4. ___ **Cancer:**
   Cancer with other disease coverage ___ Yes | ___ No
   Lump Sum ___
   Renewable Benefit Amount _____

5. ___ **Life:**
   Term ___ - ___ 5 years | ___ 10 years | _____ Other
   Whole Life ___
   Universal Life ___

6. ___ **Hospital Indemnity – "GAP Plans"**
   Current Health Plan's amount & deductible: _____
   Other options needed:
   Surgery & Anesthesia option: ___ Yes & Amount desired _____ | ___No
   Private Duty Nursing: ___ Yes | ___ No
   Emergency Accident/per occurrence: ___ Yes | ___ No
   First Occurrence Benefit Rider: options select one:
   (A)___ $500/day for 1-2 days or ___ $1,000/day for 3, 4, 5, or 6 days
   (B)___ Lump some amount/day of $30 or $1,000/day; amount selected-$_____
   Sickness rider: ___ $25 | ___ $50 | ___ $75 | ___ $100 per occurrence (select one)

7. ___ **Vision and Dental/wellness package options:** ___ Yes | ___ No

8. ___ **COBRA / HIPAA Outsourcing**

Please complete this form.
Fax - 515-309-0285 or email as an attachment - ejc@abcinc-online.com or
mail - **Access Benefit Consultants, Inc.,** 3829 71st Street, Suite A, Urbandale, IA 50322

Any question? Feel free to call 515-309-0284 or 888-590-8098