Group Benefits Comparison Request

Request Date: _____
Coverage Needed by: _____
Current Provider: _____

Company Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____

 # Full-Time Employees: _____
 # With Benefits: _____
Email Address: _____
Contact Person: _____

Current Deductible: _____
Doctor's Copay: _____
Co-insurance %: _____
Current Premium: $ _____

Current Benefits: (if any) ***Amount of Benefits:***

Hospital Supp/Accident?: _____
Long Term Disability?: _____
Short Term Disability?: _____
Critical Illness Benefit? _____

Requested Benefits:

Annual Deductible: _____
Doctor's Copay: _____
Prescription Copay: _____
Dental Benefits: ***Single*** ***Family*** _____

Optional Benefits: (Amount)

Group Gap Coverage: Yes No
Term-Life Benefit: _____
Disability Cov: _____
Critical Care: _____

Employee Census:

	Employee Name:	Date of Birth	Spouse Age	# of Children	Dental Coverage	Annual Earnings	Disability Benefits	Term Life Amount	Gap Coverage	Critical Care	Cancer/ Heart	Status: Employee Emp/Spouse Emp/Child, Family Cov.
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Special Requests:

For Companies with larger employment, please make additional copies of form.

Please fax requests to:407-740-5459 ***Email to: hhall@hlhall.com*** ***Call with questions: (407) 740-7492***