

Client Referral

FAX TO: 212 283 3104

Agent / Broker: _____

Name of Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Fax: _____

Cell / Beeper: _____ Email: _____

Total number of Employees: _____

Single (S): Employee and Spouse (ES): Employee and Child (EC): Family (F):

Current Medical Plan Design:

Medical Design that Interests you:

Carrier / Type: _____

Office Co-pay: _____

Prescription: _____

Co-Insur./ Deduct.: _____

Hosp.Co-pay / RX Deduct: _____

Additional Riders: _____

Medical Rates: _____

Effective dates: _____

Are we quoting: Medical Dental Life LTC/STC LTD/STD Other (explain)

Reason for Quote: _____

Who did you say will call the client back:

Harvey Weiner: _____

Arlene Walsh: _____

Nancy Specker: _____

IF NECESSARY, PLEASE ATTACH RENEWAL LETTER, CURRENT BILL, NYS-45 AND ANY OTHER INFORMATION THAT MIGHT BE HELPFUL.