Preliminary Group Health Insurance Quote Request Form – FAX to 513-891-3088

Company Name: _____

Address: _____

City, State ZIP: _____

Phone: _____ **Fax:** _____ **Email:** _____

Contact Name: _____ **Current Deductible:**_____

Nature of Business: _____

Census Information

Employee Age	Gender (Circle One)	Spouse's Age (If Covered)	# of Children (If Covered)		Employee Age	Gender (Circle One)	Spouse's Age (If Covered)	# of Children (If Covered)
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
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	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		
	M / F					M / F		

Insurer underwriting, agency and regulatory guidelines apply. Attach additional census pages if needed. Rev 7-11-2009

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