|  |
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| **S**3 Direct Quote Questionnaire – ***Large Group*** |

Please fill out the form and return it to S3 Direct (any of the following methods is acceptable):

Fax to: S3 Direct • 469-751-8588

E-mail: sferguson@s3directllc.com

Mail to: S3 Direct • P.O. Box 600183, Dallas, TX 75360

\*\*Please fill in all relevant information. Please do not enter any information in the black boxes\*\*

|  |  |
| --- | --- |
| S Cubed Reference Number:       | Submission Date:       |
| Broker Reference Number:       | Quote Due Date:       |
| Policy Term Dates:       |

## Risk Information

|  |
| --- |
| Name:       |
| Street Address:       |
| City:       State:       Zip:       |
| Phone Number:       Fax Number:       |
| Nature of Business:       SIC Code *(if known)*:       |

1. Are there any dependents and/or spouses to be covered?.……………………………………………………… [ ]  Yes [ ]  No

2. Are there any individuals to be covered that are over the age 70?……………………………………………….[ ]  Yes [ ]  No

3. Is there a current plan?………………………………………………………………………………………………...[ ]  Yes [ ]  No

*(If yes, please provide up to 3 years of premium loss and runs) (Also, please provide a copy of the existing plan)*

|  |  |  |  |
| --- | --- | --- | --- |
| Term | Earned Premium | Incurred Losses | Number of Losses |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

4. Can you please provide a group census? *(If yes, please send with form)* ………………………………………..[ ]  Yes [ ]  No

5. Please provide name of current carrier:

6. Should requested coverage duplicate an existing plan?……………………………………………………….…[ ]  Yes [ ]  No

7. Can you please provide any marketing material? *(If yes, please send with form)………………………………….….*[ ]  Yes [ ]  No

8. Number of group participants:

 By Ages (Years): Under 12:       12-15:       16-18:       Over 18:

9. Is the plan: [ ]  Voluntary [ ]  Mandatory

 What additional benefits does the group get on a Voluntary Basis:

 What additional benefits does the group get on a Mandatory Basis:

10. Premium Remittance: [ ]  Monthly [ ]  Quarterly [ ]  Annual [ ]  Audited

11. Is TPA handling marketing or collections?……………………………………………………………………….[ ]  Yes [ ]  No

 *(If yes, please provide the name of the TPA)*:

12. Please provide a description of the activity:

|  |
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| **S**3 Direct Quote Questionnaire – ***Large Group*** Page 2 |

|  |  |
| --- | --- |
| Group Name:        | S 3 Reference Number:       |
| Broker Name:       | Broker Reference Number:       |

## Desired Coverage Amounts

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Benefits** | **Class 1** | **Class 2** | **Class 3** | **Class 4** | **Options** |
| Accidental Death & Dismemberment |       |       |       |       |       |
| AD & D Options |       |       |       |       |       |
| Accident Medical | Primary |       |       |       |       |       |
| Excess |       |       |       |       |       |
| Weekly Indemnity | Amount |       |       |       |       |       |
| Weeks |       |       |       |       |       |
| Elimination |       |       |       |       |       |
| In-Hospital Indemnity | Amount $25-$500 |       |       |       |       |       |
| Benefit Period (6-24 months) |       |       |       |       |       |
| Waiting Period(0-30 days) |       |       |       |       |       |
| Options (Emergency) | Emergency Room/Center ($50-100 per visit) |       |       |       |       |       |
| Emergency X-ray ($25-$100 per visit) |       |       |       |       |       |
| Ambulance to ER($50-$100 per visit) |       |       |       |       |       |
| Max Visit (2-5 days) |       |       |       |       |       |
| Max hours after accident(48 or 72) |       |       |       |       |       |
| Intensive Care/Cardiac Unit($25-$500) |       |       |       |       |       |
| Waiting Period(1-7 days) |       |       |       |       |       |
| Incurral (Vesting Period)(90-365 days) |       |       |       |       |       |
| Partial Disability |       |       |       |       |       |
| Total Disability |       |       |       |       |       |
| Hospital Accident /Sickness | Amount($25-$500) |       |       |       |       |       |
| Benefit Period(5-100 days) |       |       |       |       |       |
| Waiting Period(0-14 days) |       |       |       |       |       |
| Other Coverage |       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

|  |  |
| --- | --- |
| Aggregate Limit |       |

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| **S**3 Direct Quote Questionnaire – ***Large Group*** Page 3 |

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| --- | --- |
| Group Name:        | S 3 Reference Number:       |
| Broker Name:       | Broker Reference Number:       |

**Agency Information**

|  |
| --- |
| Agency Name:       Agency Producer Number:       |
| Address:       |
| City:       State:       Zip:       |
| Phone Number:       Fax Number:       |
| Agency E-mail Address *(if any)*:       |
| Web Address:       |

## Agent/Broker Information

|  |
| --- |
| Agent/Broker Name:       |
| Main Phone Number:       Other Phone Number:       |
| Agent E-mail Address:       |

Is there a Sub-Producer?………………………………………………………………………………………………..[ ]  Yes [ ]  No

|  |
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| Requested Commission:       |
| Projected Annual Premium of Quote:       |

**Notes:**

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