PGH BENEFITS, LLC.
109 N. FAIRFIELD ST.
P. O. BOX 946
LIGONIER, PA 15658-0946
(724)238-6886 voice
(724)238-6223 fax
pghbenefits.com

GROUP BENEFITS QUOTE REQUEST

Agent(s): _____
Original Appointment Date: _____ **Follow-up Appointment Date (if scheduled): _____**

I. Client Profile

___Legal Name
___Address
___County
___Phone/Fax #
___Contact Name
___Nature of Business/SIC Code
___ Workers Compensation Carrier
___Current Census – See Attached *Employee Census Information* Form
___Copy of Most Recent Form UC-2 (PA State Unemployment Tax Form)
Please indicate which employees are ineligible and reason (ie. Part-time, covered under spouse, etc.)
___Waiting period for new hires
___Employee Contribution %
___Sect. 125 (Employee contributions on "pre-tax basis"?)

For groups of 50 or more employees

___Claims experience for prior two years (if available)
___Details of claims in excess of $25,000 in past 12 months (diagnosis, prognosis, $ amount)

II. CURRENT COVERAGES*

___**Life & AD&D** Rate: _____
Amount: _____
___**Dependent Life** Rate: _____
Amount: _____
___**Short Term Disability (STD)** Rate: ____
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
___**Long Term Disability (LTD)** Rate: ____
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
___**Vision** Rate: _____
Deductible: _____
Benefit Amounts: _____
___**Dental** Rate: _____
Deductible: _____
Benefit Amounts: _____
___**Medical** Rates: _____
Plan Type (PPO, HMO, etc.): _____
Physician Office Copay: _____
Deductible: _____
Coinsurance: _____

III. QUOTES REQUESTED

___**Life & AD&D**
Amount: _____
___**Dependent Life**
Amount: _____
___**Short Term Disability (STD)**
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
___**Long Term Disability (LTD)**
Elimination Period: _____
Benefit Period: _____
Benefit Amount (% of Income): _____
___**Vision**
Deductible: _____
Benefit Amount: _____
___**Dental**
Deductible: _____
Benefit Amounts: _____
___**Medical**
Plan Type: _____
Physician Office Copay: _____
Deductible: _____
Coinsurance: _____

*In lieu of completing the "Current Coverages" information, a copy of the current carrier's most recent invoice and benefits booklet can be submitted.

Employee Census Information

Business Name _____

Business Address _____

Agent Name(s) _____

Name	**Sex**	**Date of Birth**	**Date of Hire**	**Dependent Status***	**Home Zip Code**	**Occupation** *Required for Disability Quotes*	**Annual Income** *Required for Disability Quotes*
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

*E=Employee Only, SP=Employee & Spouse, PC=Employee & Child(ren), F=Family

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