

CASE INFORMATION



Westbrook Financial Services, Inc.

Company Name: _____
 Address: _____
 City/State/Zip: _____
 Phone Number: _____
 SIC Code: _____ Nature of Business: _____
 Renewal Date: _____

Current Medical Carrier: _____ Effective Date: _____
 Current Dental Carrier: _____ Effective Date: _____
 Current Life Carrier: _____ Effective Date: _____
 Current STD Carrier: _____ Effective Date: _____
 Current LTD Carrier: _____ Effective Date: _____

Funding Type: _____ Full _____ Partial Self-Funded _____ Self-Funded Employer Contribution: _____ Employee: _____ Dependent: _____

Number of Eligible Employees: _____ Number of Employees Quoting: _____

Benefit/Rate Information

MEDICAL

	Deductible	Coinsurance	OPX	OV Copay	ER Copay	RX Copay	Rates			Family
							EE	EE/Sp	EE/Ch	
PPO										
HMO										

DENTAL

	Deductible	Coinsurance	Annual Max	OV Copay	Ortho Ded.	Orth Max	Rates			Family
							EE	EE/Sp	EE/Ch	
PPO										
DMO										
Indemnity										

LIFE/AD & D

Class	Description	Volume	Rate Per \$1,000	
			Life	AD & D
1				
2				
3				

STD

Volume	Duration	Max Benefit	Rate Per \$10

LTD

Volume	Duration	Max Benefit	Rate Per \$100

OTHER BENEFITS

Benefit	Carrier	Benefit Description	Rate

COMMENTS:

