



## Quote Request Form for Small Business 1-100

**H.M. Gousha Insurance Services LLC** License: 0L43500

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Owner/Key contact: \_\_\_\_\_

How long have you been in business? \_\_\_\_\_ Industry: \_\_\_\_\_

Is your company a: C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Partnership ☐ Sole Prop ☐

Does your company provide health insurance? Yes ☐ No ☐ Renewal date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a health insurance agent? Yes ☐ No ☐ Name: \_\_\_\_\_

How many employees do you have? Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_

How many employees will be covered for health insurance? \_\_\_\_\_

Do you file an EDD quarterly wage report, a DE 9C? Yes ☐ No ☐

Employers Contribution? Employees \_\_\_\_\_ Dependents \_\_\_\_\_ (% or \$)

Do any employees travel to Mexico for medical services? Yes ☐ No ☐

Do you have any EE's on or ready for Medicare? Yes ☐ No ☐

Anyone on COBRA? Yes ☐ No ☐ Who does your COBRA admin? \_\_\_\_\_

Do you have an employee handbook? Yes ☐ No ☐

Would you like to explore ways to use pre-tax dollars to purchase coverage? Yes ☐ No ☐

Do you or a family member own an interest in any other businesses? Yes ☐ No ☐



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# GROUP HEALTH INSURANCE – INITIAL QUESTIONNAIRE

**dates as: (xx/xx/xxxx)**

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_ Broker: \_\_\_\_\_

Current Plan(s): \_\_\_\_\_

Premium: \_\_\_\_\_

**Employee Information: (each family member should be listed on separate line with each member of same family having same ID #)**

**Coverage: EE = Employee, S = Spouse, CH= Child -- IFP = Individual Family Plan**

[illegible]



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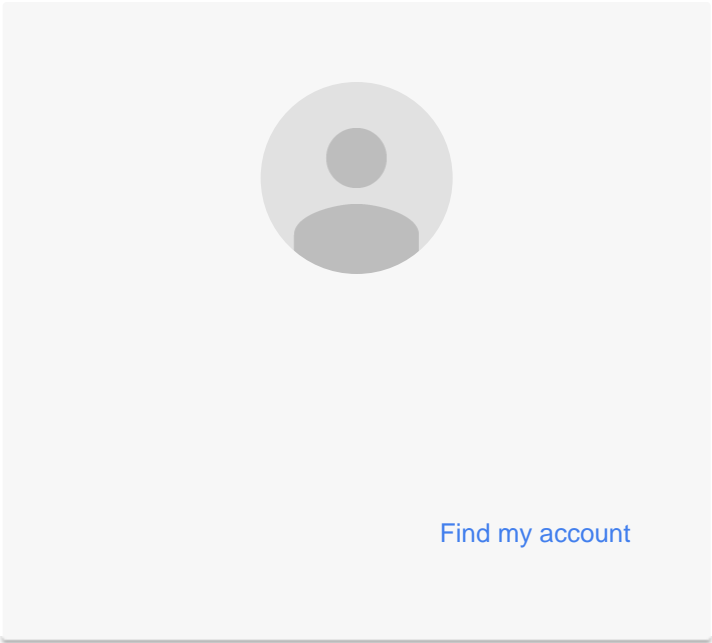


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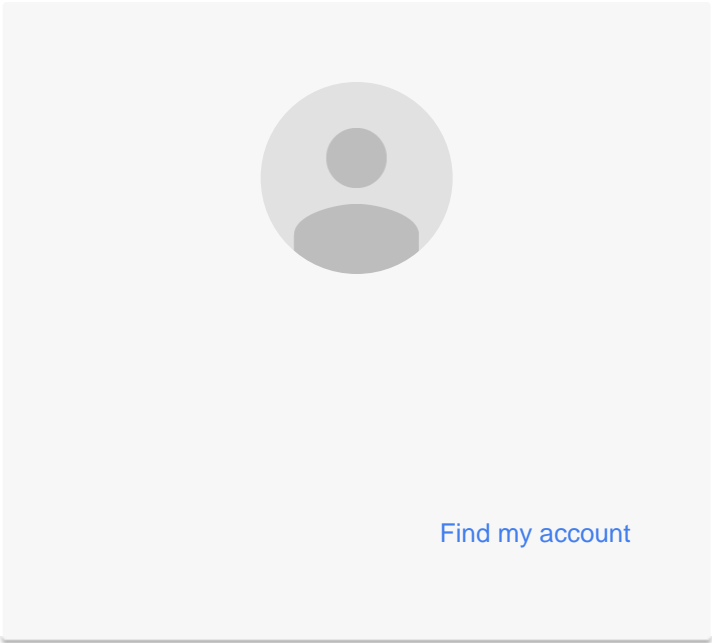
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