BARROOD AGENCY, INC.

Request for Group Ancillary Benefits Quotation

All Requests Must Include Census

NOTE: NOT ALL PLANS REQUESTED ARE AVILABLE WITH EACH CARRIER

Group Name: _____ **Zip Code:** _____ **Effective Date:** _____

SIC CODE AND/OR INDUSTRY (MANDATORY): _____

Broker Name:_____ **Agency:** _____

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

Current Carrier & Rates: _____ **Renewal Date:** _____

(PLEASE ATTACH CURRENT BENEFIT BOOKLET FOR 51+)

DENTAL COVERAGE

☐ Horizon ☐ American General ☐ MetLife ☐ Guardian ☐ Oxford OBM ☐ Bollinger

Deductible: ☐ $0 ☐ $25 ☐ $50 ☐ $100 ☐ Other_____

Takeover: ☐ Yes ☐ No Wave Waiting Period: ☐ Yes ☐ No

COINSURANCE

In Network: Preventative: _____% Basic: _____% Major: _____%

Out of Network: Preventative: _____% Basic: _____% Major: _____%

Lifetime Max: ☐ $1000 ☐ $1500 ☐ $2000 ☐ Other_____

Ortho Benefit: ☐ Yes ☐ No Max: ☐ $750 ☐ $1000 ☐ $1500

LIFE COVERAGE

☐ USAble Life ☐ American General ☐ MetLife ☐ Guardian

Coverage Amount:$_____

Schedule Amount Based on: Flat _____ Times Salary _____ (Need Salary on Census)

Class I _____ Class II _____ Class III _____ Class IV _____

Please Note: Completed forms can be emailed to insurance@barrood.com. Questions regarding your quotes should be directed to 800-275-6727.

BARROOD AGENCY, INC.

Request for Group Ancillary Benefits Quotation (continued)

DISABILITY (job title & salary must be on census)

☐ USAble Life ☐ American General ☐ MetLife ☐ Guardian

STANDARD

Benefit Percentage: _____% Max Weekly Benefit: _____% Max Benefit Period: _____weeks

LIMITED

Has this group been in business for more than 2 years: ☐ Yes ☐ No

Benefit Percentage: _____% Max Weekly Benefit: _____% Benefit Duration: _____

Elimination Period: ☐ 90 Days ☐180 Days ☐Other: _____

NJ TDB/ NY DBL

☐ Zurich NJ TDB ☐ Zurich NY DBL

VISION

☐ American General ☐ Block Vision ☐ Guardian

Eye Exam Frequency: ☐ 12 Months ☐ 24 Months ☐Other: _____

Frames Frequency: ☐ 12 Months ☐ 24 Months ☐Other: _____

Lens Frequency: ☐ 12 Months ☐ 24 Months ☐Other: _____

Contacts Frequency: ☐ 12 Months ☐ 24 Months ☐Other: _____

Copayment: ☐ $0 ☐ $5 ☐ $10 ☐ $20 ☐ $30 ☐Other: $_____

Please Note: Completed forms can be emailed to insurance@barrood.com. Questions regarding your quotes should be directed to 800-275-6727.