Good Neighbor Insurance
620 S. Winthrop St., Gilbert, AZ 85296
Tel: 480-813-9100 / Fax 480-813-9930
E-MAIL: jeff@gninsurance.com
WEBSITE: gninsurance.com

REQUEST FOR GROUP QUOTE

Please Print or Type All Sections

Mission Name____

Street Address ____________________________________Contact Person________________

City_____________________________State______ Postal Code ________Country _________

Phone Number____________________ E-mail ______________________________________

Nature of Business_________________________________Desired Effective Date___________
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BENEFIT PLANS DESIRED

Deductible: [ ]$250 [ ]$500 [ ]$1000 [ ]$2500 [ ]$5000

Lifetime Maximum: [ ]$1,000,000 [ ]$5,000,000

Life Insurance: [ ]$10,000 [ ]$25,000 [ ]$50,000 [ ]Other ____________________

Waiting Period - New Employees [ ] 30 days [ ] 60 days [ ] 90 days [ ]Other____________________

Are any employees presently on COBRA? [ ] Yes [ ] No
If YES, please provide the following information. (Attach additional sheets if necessary.)

Employee____ Date of Departure____________

Employee____ Date of Departure____________

Employee____ Date of Departure____________

Employee____ Date of Departure____________

Has another Insurance carrier refused your group? [ ] Yes [ ] No

Total number of employees _______________ (including US-based & intl. employees)

Total number of eligible employees____________ (intl. employees only)

How many employees have been employed less than six months?___________________________

Do you expect the number of employees to vary more than 10% during the next 12 months?

If YES, please explain ____

What is the employee and/or self-employed filing status with the IRS?

(Check all boxes that apply) ☐ W-2 ☐ 1099 ☐ No Compensation

Do you presently have group medical insurance: [ ] Yes [ ] No

If YES, please attach the following:

1. Copy of present policy and/or booklet describing benefits.
2. Copy of most recent billing statement from present carrier.
3. Copy of most recent 3 years claims experience.
   (In most instances, this can be obtained from your present or past carrier(s))

Please answer the following questions to the best of your knowledge. If you answer YES to any of these questions, please provide details in the space provided below.

1. Has any employee or dependent suffered from a condition which resulted in a claim of $2500 or more during the last 3 years? [ ]Yes [ ] No
2. Are any employees or dependents currently pregnant? [ ]Yes [ ] No
3. Are any employees or dependents presently hospitalized, confined at home or treatment facility, disabled or incapacitated? [ ]Yes [ ] No
4. Are any employees not actively at work performing his/her normal duties due to illness or injury? [ ]Yes [ ] No
5. Are you aware of any circumstances, chronic or continuing medical, mental or nervous conditions which can be expected to produce ongoing claims? [ ]Yes [ ] No

Additional Comments: (Attach additional sheets if necessary.)

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