

Please complete and return this form to:

Gary B. Kynard CA#0553962

(310) 622-4552 office

(323) 291-7789 fax

Spreadsheet files may be e-mailed to

Info@medicalinsurancebiz.com

Company Name: _____

Agent Name: **Gary Kynard**

City, State, Zip: _____

Affiliation: _____ Agent #: _____

Address: _____

County: _____

Nature of Business/SIC: _____

Phone: _____ Fax: _____

Agency Mgr.: _____

of years in business: _____

DOB: _____ S.S.#: _____

Effective Date: _____

Total # of employees: _____

Deductible(s): _____
Coinsurance(s): _____
Stop Loss/Out of Pocket: _____
Circle: CMM PPO POS <u>HMO</u>

Employer Contribution: _____
Existing Carrier: _____
Current Rates: _____ Renewal Rates: _____
Is Full Takeover Needed: _____
of Employees on COBRA: _____
Reason: Employment _____ Medical _____
of Employees Related: _____
Health Problems: Y N

Options

- Maternity
- Prescription Drug
- Supplemental Accident
- Preventive Care
- Doctor's Visit Copay

Additional Notes: _____

DENTAL	Indemnity		PPO
Coinsurance:	100/80/50	80/80/50	
Deductible:	\$25	\$50	\$100
Annual Max:	\$1000	\$1500	Orthodontia: Yes No

LIFE
Flat Amount: _____
Class Breakdown: _____
Dependent Life: _____

LTD elimination period: _____ of salary _____

Max. \$ Benefit: _____

STD Accident _____ Sickness _____ Duration _____ % of salary _____

Max. \$ Benefit: _____

