

GROUP INFORMATION FORM

Phil Brown Insurance Agency
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COMPANY NAME:	TAX ID #:
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ADDRESS:

CITY:	STATE:	ZIP:	COUNTY:
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DECISION MAKER:	CONTACT PERSON:
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PHONE: ()	FAX: ()
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E-MAIL:

NATURE OF BUSINESS:

CURRENT GROUP CARRIER:	RENEWAL DATE:
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PERCENTAGE OF PREMIUM PAID BY EMPLOYER:

TOTAL NUMBER OF FULL-TIME EMPLOYEES:

TOTAL NUMBER OF EMPLOYEES COVERED ON HEALTH INSURANCE PLAN:

CURRENT PLAN DESIGN: (Please complete below or attach plan summary)

DEDUCTIBLE:	OUT OF POCKET MAX:
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OFFICE VISIT COPAY:	RX COPAYS:
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COMMENTS: