Association Insurance Program
Group Health Quote Worksheet

Association Name: _____

Group/Organization Name: _____

Contact Person:_____

Telephone:_____ Fax:_____ E-mail:_____

Nature of Industry: _____

Address:_____

City:_____State:_____Postal Code:_____

Requested Effective Date: _____

Total number of full-time employees:_____ Total number of full-time employees to be insured:_____

Does your organization currently have group medical insurance? ☐ Yes ☐ No

(If yes, please provide name of carrier, current and renewal rates, schedule of benefits, (and claims experience if available)_____

EMPLOYEE CENSUS (all full-time employees and birth date must be included to obtain quote)

***Coverage needed: You can attach a separate census or additional pages as necessary**

W = Waiving Coverage ● EE = Employee Only ● EE + CH = Employee + All Child(ren)

EE + SP = Employee + Spouse ● EE + Family = Employee + Spouse + Child(ren)

Note: Salaries required for Disability Insurance and/or salary-based Life Insurance

Gender	Employee Name (optional) (indicate if COBRA employee)	Coverage needed*	Employee Birth Date	Spouse Birth Date	Child(ren) Birth Date(s)	Annual Salary
Male	*(Sample) John Doe*	*EE + Family*	*04/15/70*	*2/10/72*	*01/01/00; 05/02/15*	*$75,000*

Please complete this form and return via email, fax or mail:

Michael George @ AMJ Insurance, Inc.

PO Box 580, Fishers, Indiana 46038

☎ Direct: 317.735.4102 Fax: 800.852.6810 ✉ mgeorge@amj-ins.com