Kimmel Benefits Company

Company Name:	**Number of Years in Business:**
Contact Name:	**Phone:**
Type of Business:	**Fax:**
Address:	**E-Mail:**
	Employer Contribution: _____% Employee _____%Dependents
Current Medical Plan	**Current Dental Plan**
Carrier:	**Carrier:**
Plan Design: **Deductible**_____	**Plan Design:** **Deductible**_____
Coinsurance _____	**Annual Max.**_____
Office Visit Copay_____	
Renewal Date:	**Renewal Date:**
Rates: **Current** **Renewal**	**Rates:** **Current** **Renewal**
Employee	***Employee***
Employee + Spouse	***Employee + Spouse***
Employee + Child(ren)	***Employee + Child(ren)***
Employee + Family	***Employee + Family***

Company Census

Last Name	Gender	DOB	Spouse Covered?	Spouse DOB	# of Covered Children	Home Zip Code

PLEASE E-MAIL THIS FORM TO SCOTT@KIMMELBENEFITS.COM OR FAX TO (425) 883-8941

* All information disclosed is confidential and will be provided only to insurance carriers for rate quoting purposes.