

# PROFESSIONAL INSURANCE SERVICES, INC.

DATE \_\_\_\_\_

NAME OF BUSINESS \_\_\_\_\_

TYPE OF BUSINESS \_\_\_\_\_ SIC Code \_\_\_\_\_

BUSINESS CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OPTIONS:   \_\_\_ ACCIDENT   \_\_\_ DENTAL   \_\_\_ DRUG CARD   \_\_\_ VISION   \_\_\_ O.V. CO-PAY  
           \_\_\_ MATERNITY   \_\_\_ LIFE   \_\_\_ DEP. LIFE   \_\_\_ WELLNESS   \_\_\_ STD   \_\_\_ LTD

DEDUCTIBLES   \$ \_\_\_\_\_   \$ \_\_\_\_\_   \$ \_\_\_\_\_   \$ \_\_\_\_\_

COINSURANCE:   \_\_\_ 80%   \_\_\_ 70%   \_\_\_ 50%           HSA:   \_\_\_ 100%

	EMPLOYEE NAME	EMPLOYEE		SPOUSE	HOW MANY CHILDREN	LIFE VOLUME	DISABILITY	
		AGE	SEX	AGE			%	ANNUAL SALARY
1								
2								
3								
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