ACCE REQUEST FOR QUOTE

ACCE EMPLOYEE BENEFIT PLANS

1 SCAN AND EMAIL THIS COMPLETED FORM TO: info@acceinsurance.org

2 COMPLETE THE FORM ONLINE AT: www.acceinsurance.org

3 CALL ACCE INSURANCE SALES: 1-800-601-1016

1. PLEASE PROVIDE YOUR ORGANIZATION'S INFORMATION

Contact Name _____ Phone Number ( ) _____

Title _____ Fax Number ( ) _____

Organization _____ Email Address _____

Street Address _____ City, State Zip _____

2. PLEASE CHOOSE PLAN(S) AND BENEFIT OPTIONS

☐ **401(k) Plan** Number of Active Employees: ☐ Number of Terminated Employees with a Balance in Plan: ☐

☐ **457(b) Plan** Number of Active Employees: ☐ Number of Employees Eligible for Plan: ☐

☐ **Group Term Life and AD&D** Benefit Options: ☐ 2.5x Salary ☐ 2x Salary ☐ 1.5x Salary

☐ **Long-Term Disability** Elimination Period Options: ☐ 90-Day Elimination Period ☐ 180-Day Elimination Period

☐ **Short-Term Disability** Benefit Duration Options: ☐ Option 1: 9 Weeks ☐ Option 2: 22 Weeks ☐ Option 3: 12 Weeks

☐ **Dental PPO**

☐ **Vision**

☐ **Voluntary Accident w/ Travel Benefits:** ☐ **Employee** ☐ **Family**

☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $300,000 ☐ $500,000

3. PLEASE CHOOSE WAITING PERIOD FOR GROUP INSURANCE PLANS *Applicable to Term Life and Disability Plans only*

Insurance Waiting Period - coverage effective 1st day of the month following: ☐ Hire date ☐ 30 days ☐ 60 days ☐ 90 days

4. PLEASE PROVIDE EACH EMPLOYEE'S INFORMATION **Dependent coverage will be quoted as available for plan selected*

CODES: **E** - Employee Only **S** - Spouse and Employee **C** - Children and Employee **F** - Full Family (Spouse, Children and Employee)

EMPLOYEE NAME	SALARY	EMPLOYEE DOB	COVERAGE DESIRED* USE CODES: E,S,C or F