Group Quote Request

Name of Company:		Began business on:	
Address:			
Phone :	Fax:	Email:	
Contact Person:			
Current Insurance Co	mpany:	· · · · · · · · · · · · · · · · · · ·	

Type of Coverage requested (check all that apply)

- □ Medical
- □ Life
- Dental
- □ Short Term Disability
- □ Long Term Disability

List of Employees Working at least 30 hrs/wk.

Name	Age	M/F	Spouse Age	# Child- ren	List Current Medical Conditions
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All furnished information will be kept confidential.

David Lowe Insurance Agency Mail: PO Box 12723 Florence, SC 29504-2723 Fax:(843)669-7144 Email: <u>david@loweins.com</u>