

# Rapid Cost Estimate Form

Company Name: \_\_\_\_\_  Corporation  Partnership  Sole Prop.  S-Corp.  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Company Information:**

1. Total number of employees eligible to participate in the dental plan: \_\_\_\_\_
2. Approximate annual employee turnover rate: \_\_\_\_\_%
3. Do you have a Cafeteria Benefits Plan with medical and/or dependent flexible spending accounts?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No
4. Nature of company's business and/or SIC Code: \_\_\_\_\_
5. Address of additional employer sites (excluding the address listed above):  
 Location 2: \_\_\_\_\_ # of employees: \_\_\_\_\_  
 Location 3: \_\_\_\_\_ # of employees: \_\_\_\_\_
6. Number of proposals needed: \_\_\_\_\_

**Current Dental Plan Information:**

Please check here if you do not currently offer a dental plan

Insurer Name: \_\_\_\_\_ Year Policy Began: \_\_\_\_\_ Renewal Date: \_\_\_\_\_  
 Broker Name (if applicable): \_\_\_\_\_ Telephone: \_\_\_\_\_

	<u>Current Rates</u>	<u>Number of Employees Enrolled</u>
Employee Only		
Employee/Spouse		
Employee/Child		
Employee/Children		
Employee/Family		

1. Company pays \_\_\_\_\_% of the cost for employees and \_\_\_\_\_% of the cost for dependents.
2. The deductible per individual is \$ \_\_\_\_\_
3. The Annual Maximum per individual is \$ \_\_\_\_\_
4. The following percentages are paid for various types of procedures:
 

_____ % for Preventive Care	<i>Note:</i> Please provide a copy of your dental plan's description of benefits (which states coverage, deductibles, maximum annual paid claims, etc.) if available.
_____ % for Basic Care	
_____ % for Major Care	
_____ % for Orthodontic Care	
5. Historical Paid Claims (please include any available information):  
 2007: \$ \_\_\_\_\_  
 2006: \$ \_\_\_\_\_  
 2005: \$ \_\_\_\_\_

*Thank you for completing this information.*  
*Please fax or mail this form to Benefits Administration, Inc. to receive your cost estimate*  
**Benefits Administration, Inc. Attn: C.P. Coyner**  
**1913 Huguenot Road, Suite 100**  
**Richmond, VA 23235**  
**Phone: 804-379-2218 or 888-379-2218 Fax: 804-379-2219**