Quote Request Form

North Carolina Medical Society Employee Benefit Plan

Please type or print. Asterik (*) denotes required information. Quotes presented will be based on rates effective as of the Coverage Effective Date.

A. EMPLOYER INFORMATION

EMPLOYER NAME* (Provide complete legal name)			SPECIALTY*	
LOCATION ADDRESS*	CITY	STATE	ZIP CODE	COUNTY*
MAILING ADDRESS (If different than Location Address)	CITY	STATE	ZIP CODE	COUNTY
PHONE NUMBER*	FAX NUMBER	E-MAIL	CONTACT PERSON* ☐DR. ☐MR. ☐MS.	TITLE
COVERAGE EFFECTIVE DATE*	CURRENT CARRIER	RENEWAL DATE	REFERRAL SOURCE	

B. CENSUS INFORMATION (duplicate and attach additional sheets if necessary)

EMPLOYEE NAME* (First and Last)	**DATE OF BIRTH***	**COVERAGE TYPE* (Check all that apply)**
		☐Employee ☐Spouse ☐Child ☐Children
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Please indicate whether you would like more information about these products:
Life/AD&D Insurance ☐Yes ☐No
Dental Insurance ☐Yes ☐No

Submitted by:______________________________________ **Date:**____________________
(Authorized Representative of Curi Benefits Solutions)

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