

# AGENCY MARKETING SERVICES

P O BOX 4020, TORRANCE, CA. 90510-4020 | 800-334-7875/FAX310-534-1159

see us at <http://www.amsinsure.com> / email [jbeyer@amsinsure.com](mailto:jbeyer@amsinsure.com)

California State License # 0294220

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## Email request

Census Information Request:

We have received your request to quote on an employee benefit plan. As brokers, we request plans from all available carriers so that you may reliably evaluate which plan meets your company's needs. Upon receiving the information, a comprehensive quote will be prepared and emailed. Looking forward to meeting with you soon.

Sincerely,

John A. Beyer, CLU

Contact Name:	Title:
Company Name:	Company Size:
Industry Type:	SIC code
Address:	City, Zip:
Phone #:	Fax #:

Number of employees to be covered:	Do you have a current insurance carrier:
If yes, carrier and expiration date of current plan:	Types of health plans with current carrier:
Types of health plans would like in a new plan:	Additional coverage would like with new plan:
Anticipated start date of new plan:	% premium company will cover:
Preferred maximum deductible:	Employee:                      Dependent:
Are there employees that live outside of the state:	Number of years company in business:
Additional requirements:	

- 1) Required for Medical and Dental Quotes
- 2) Required for Life, Disability, 401K Quotes

Note: do not include Part Time Employees. You can define Part Time as 20 hours or 30 hours per week, which means all non part time employees, are eligible for coverage. Show any full time employees waiving coverage or who are on cobra in the column provided. For cobra employees please note any medical condition separately.

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DATE: ( ) FOR YOUR INFORMATION ( ) PLEASE CALL ( ) AS REQUESTED  
NUMBER OF PAGES SENT( )+TRANSMITTAL  
CALL IF MISSING PAGES

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<b>2</b> Name/Occupation	<b>1/2</b> <u>Date of Birth</u> (MO/YR) or (AGE)	<b>1/2</b> <u>Sex</u> M/F	<b>1</b> <u>Dependent Status</u> Sng Sp/Age #Chld			<b>1</b> (C) Cobra (W) Waive	<b>2</b> Monthly Salary	<b>1</b> ZipCode	<i>(optional)</i> Smoke Y/N
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## BROKER AUTHORIZATION LETTER

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**Company Name:** \_\_\_\_\_ . ;

hereby retains Agency Marketing services, as their representative.

We authorize them to obtain on our behalf the rates and plan information for the employee benefit plans checked below.

A separate listing of the companies presented to us by Agency Marketing Services, Dated and signed at the time of presentation attached to this memorandum. It will constitute our notice that such plans were presented to us at that time.

Should we purchase one of the plans presented by Agency Marketing Services, they will receive all commissions due to their efforts. This shall constitute our Broker of Record letter regarding such plans.

We agree to furnish all necessary information required to obtain a preliminary and final quotation. Due to the nature of our company and the make up of our employees, we will comply with AB 1672 legislation for groups of 3 to 50 employees or those provisions governing all employee groups.

**GROUP:**

**LIFE** \_\_\_\_\_ **MEDICAL** \_\_\_\_\_ **DENTAL** \_\_\_\_\_ **DISABILITY** \_\_\_\_\_ **PENSION** \_\_\_\_\_ **SALARLY** \_\_\_\_\_

Signed: X \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

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