



**Phone: 877-768-6364**

**Fax: 847-852-4449**

**NUA-i.com**

**Small Group Plan Application:**

**Please check all that apply**

- Group health insurance quote     Group Vision
- Group Dental                                     Group Life
- Group Disability                                     Wellness

**Company Name:** \_\_\_\_\_

**Sic Code:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

For other locations please include additional zip codes: \_\_\_\_\_

**Current Carrier Name:** \_\_\_\_\_

**Renewal Date:** \_\_\_\_\_

**Any Known Medical Conditions:** \_\_\_\_\_

**Renewable Rates if available:** (Please include when fax or emailing)

**Current Census:** (Please include when fax or emailing)

- Please include any employees in the waiting period
- Be sure to identify type of business entity on census form.  
If Non-C-Corp, please provide names of 2% or more shareholders.

**Current Plan Design:** (Please include when fax or emailing)

- If a current Schedule of Benefits is not available please provide a description of your current plan design including 1) individual and family deductible 2) In network coinsurance 3) Individual and family Out of Pocket Maximum 4) Prescription benefit 5) Office visit co-pay.

**Do you currently have the following in place?**

**(Please check all that apply)**

- FSA       Premium Only Plan (POP)       HRA  
 HAS       Disability       Dental       Vision

**Please Fax this form and additional paperwork to (847) 852-4449.**

**If emailing documentation please send to: [Joel@NUA-i.com](mailto:Joel@NUA-i.com)**

**\*Please use your company name in the subject line when emailing additional attachments.**

**THANK YOU!**

NUA-i is not an insurance carrier but an independent auditing source for the purpose of cost reduction.