



Return to:  
 employeebenefits@ashleyinsurance.com  
 PHONE: (410) 763-9000  
 FAX: (410) 763-8210

EMPLOYER: \_\_\_\_\_ INDUSTRY: \_\_\_\_\_ CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX: \_\_\_\_\_

- Health
- Life/AD&D
- Weekly Disability
- Long Term Disability
- Dental/Vision
- LTC

**Health:**  
 Date of Birth  
 Physician  
 Coverage Level  
 Gender

**Group Life:**  
 Date of Birth  
 Gender  
 Salary  
 Job Title (if based on classes)  
 Class Info (as applicable)

**Dental:**  
 Date of Birth  
 Coverage

**Group LTD:**  
 Date of Birth  
 Gender  
 Salary  
 Job Title  
 Zip Code

**Group Weekly DI:**  
 Date of Birth  
 Gender  
 Salary/ Title  
**LTC:** DOB/Health info

Employee Name or ID #	DOB 00/00/00	Gender	Coverage Level♦	Smoker Yes/No	Occupation	Salary	Full Time / Part Time w/DOH	Physician

Comments: \_\_\_\_\_  
 Waiting period for new hires \_\_\_\_\_ Are any employees married to each other? Are there any employees living out of state?  
 Employer contribution: \_\_\_\_\_ % for employees \_\_\_\_\_ % for dependents Indicate employees who live out of state.  
 Current Plan: \_\_\_\_\_ Current Rates: \_\_\_\_\_ RX Benefit \_\_\_\_\_ Renewal Date \_\_\_\_\_

♦ Coverage Description:  
 I: Individual H/W: Husband/Wife F: Family P/C: Parent w/1 Child P/Children: Parent w/2 children  
 1: Medicare Individual 2: Medicare Husband/Wife