



## REQUEST FOR GROUP QUOTE

### EMPLOYER INFORMATION

\*Group Name \_\_\_\_\_

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

\*City \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip: \_\_\_\_\_ \*SIC \_\_\_\_\_

Type of Industry \_\_\_\_\_

\*Total number of Employees (Excluding COBRA) \_\_\_\_\_ \*Number of Ineligible Employees: \_\_\_\_\_

\*Number of COBRA Participants: \_\_\_\_\_ \*# of Full-Time Employees.: \_\_\_\_\_

\*Number of Participating Employees: \_\_\_\_\_ \*# of Participating Dependents: \_\_\_\_\_

### GROUP HEALTH INFORMATION

1. Is any person to be covered unable to work due to injury or illness? Y or N
2. Is any person unable to perform the normal duties in their customary employment or activity? Y or N
3. Are any dependent children incapable of self-support because of physical or mental disability? Y or N
4. Is any person currently hospitalized or been told extensive medical treatment, surgery, or hospitalization is required? Y or N
5. Is any person being treated for heart disease, stroke, cancer, kidney disorder, Aids, Aids Related Complex, Chronic respiratory disease or other serious condition? Y or N
6. Has any person suffered a condition which resulted in expenses of \$5000 or more or been hospitalized during the past 2 months? Y or N
7. Is there any person being treated for alcoholism or Chemical Dependency or been advised to seek treatment? Y or N
8. Is any person currently pregnant? Y or N How Many? \_\_\_\_\_ Due Date(s) \_\_\_\_\_
9. Are any persons included who are not employees for the purpose of Workers Compensation law or similar legislation? If yes, provide name and title. Y or N  
Name: \_\_\_\_\_ Title: \_\_\_\_\_

**PROVIDED COMPLETE INFORMATION TO ALL YES ANSWER ON A SEPARATE SHEET OF PAPER**

### AGENT INFORMATION

\*Agent Name \_\_\_\_\_ \*Contact \_\_\_\_\_

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

\*Phone Number: \_\_\_\_\_ \*Fax \_\_\_\_\_ \*Email \_\_\_\_\_

\*Signature \_\_\_\_\_ \*Date \_\_\_\_\_

### CHECK LIST

\_\_\_ \*Employee Census (Birth date, gender, dependent status, city, state, zip)

\_\_\_ \*Requested Plan Design (Page two)

**For groups over 150 employees or groups with prior experience, we need:**

\_\_\_ \*Monthly paid claims and corresponding enrollment for past 24 months

\_\_\_ \*Shock loss data for all claims paid at or above 50% of the specific deductible

\_\_\_ \*Current benefit schedules for the last 24 months, to include plan change information

\_\_\_ \*Current and renewal rates, to include specific and aggregate premium rates, aggregate factors and administration fee (with all included services)

\* Required information



## EMPLOYER'S PLAN OPTIONS

Circle any plan option available for each benefit type to create your custom plan(s)

BENEFIT TYPE	PLAN OPTIONS					PLAN SELECTIONS		
						ONE	TWO	THREE
Individual Deductible Options*	\$0	\$250	\$500	\$1,000	\$2,000 HSA***			
	Out of network deductible options must be 2 times the in network deductible option with a minimum of \$250							
In Network Coinsurance Options	90%	80%	70%	60%	100% HSA			
Out of Network Coinsurance Options**	50%	0%						
Office Visit (OV) Copay Options	\$10	\$20	\$30	\$40	N/A HSA			
Specialist Office Visit Copay Options	\$10	\$20	\$30	\$40	N/A HSA			
Pharmacy Copay Options G/B/NF****	\$10/\$25	\$15/\$30	\$20/\$40	\$15/\$30/\$50	N/A HSA			
Individual Out of Pocket Maximums- In Network	\$500	\$1,000	\$2,000	\$3,000	\$2,000 HSA			
Individual Out of Pocket Maximums – Out of Network	Must be 2 times the in-network maximum							
Desired PPO Network	Interplan	First Health (CCN)	PHCS					

\* 2 deductible maximum per family

\*\* Out-of-Network expenses are subject to Usual, Customary and Reasonable fees. The Member is responsible for all charges in excess of UCR.

\*\*\* HSA is a combined in-network and out-of-network deductible

\*\*\*\* G/B/NF: Generic/Brand/Non-formulary

Office visit copays and RX copays are not included in the out of pocket maximum.