

Today's Date:	Proposal Needed Date:	Desired Effective Date:	Internal Use Only AE:
<b>Group Information</b>			
Group Full Legal Name:			
Contact Name:			
Phone #:	Fax #:	Email:	
Group Physical Address:			
City:	State:	Zip:	
<b>Broker Information</b>			
Broker Name:		Email:	
Phone:	Fax:	Broker of Record: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If group is over 50 employees indicate Broker Commission: <input type="checkbox"/> PHP Standard _____ % Flat			
<b>In-Service Area Census Information</b>			
<b>Commercial</b>			
Total # In-Service Area Employees			
# Part-Time/Seasonal Employees		Minus	
# Employees in Waiting Period		Minus	
Total Employees Eligible for Health Coverage		=	
# Employees waiving without other coverage		Minus	
# Employees waiving with other coverage		Minus	
# Enrolling Employees: (if providing a current carrier bill this # must match, if not explain difference)		=	
Is this a Class Carve-Out? (minimum of 4 enrolling employees required) <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Quote Information</b>			
# COBRA or State 6-Month Continuation Participants:		Effective Dates :	
Does the group employ over 50 <b>Total Employees</b> nationwide (include part-time, seasonal, full-time)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the group have over 50 <b>Eligible Employees</b> nationwide (include employees waiving coverage)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the group on at least 50% of its working days in the preceding year employ 20 or more total employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, does the group elect Medicare as <input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
Type of Business/SIC:	Years in Business:		
Current Carrier:	Years with Current Carrier:		
Waiting Period:	Employer Contribution:	EE _____	Dep _____
# Hours worked to be Eligible (min 20):	Workers Comp: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sole Carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Benefits:		
If not Sole Carrier list other carrier(s)/rates:	(List: HMO/PPO/POS, doctor/hospital/Rx copays/dd)		
	Is group offering an HSA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If large group, list plans you want quoted (HMO/PPO/Office Copay/Rx Copay etc.):			
<b>Rate Information</b>			
	<b>Current</b>	<b>Renewal</b>	
Employee Only			
EE + Spouse			
EE + 1			
EE + Child(ren)			
EE + Family			