Health Insurance Program Quote Request

In order to provide you with an accurate and timely quote please fill out this form and the Risk Appraisal form in their entirety. Once complete you can fax or email the completed forms to:

Sales Consultant	FAX:	**(425) 643-6728**
Captial Benefit Services, Inc.	PHONE:	**(425) 641-8093**
Bellevue, WA 98007	EMAIL:	sales@epkbenefits.com

In order to obtain a quote, our carriers require all sections of this form to be completed.

Please let us know how you heard about us.

_____

BIAW Web 12

Group Information

Company Name:	Phone:
Contact Person:	Fax:
Address:	Email:
City, State, Zip:	Date Business Started:
Nature of Business:	SIC Code:

Are you a member of a trade association(s) in Washington? ◯ Yes ◯ No

If yes, please provide: Which Association? _____ Member ID #: _____ Member Since: _____

I authorize the Trust Consultants to provide our company with a proposal for the Trust.

Authorized Representative: Date:

Current Health Insurance

Current Coverage ☐ Group Medical ☐ Group Dental ☐ Individual Policies ☐ None

CURRENT INSURER_____ TRUST / PROGRAM_____ RENEWAL DATE_____

*How long have you been with your Current Insurer?*_____

Please attach a summary of benefits of your current medical (and dental if applicable) plan or provide the following:

Benefit Level (80/20):_____ Copay:_____ Deductible:_____ Rx Benefit:_____

	CURRENT RATES AS OF:_____		RENEWAL RATES AS OF:_____	
	Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
Employee				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

What percentage do you pay toward the cost for Employees? _____% Dependents?_____%

(The company must pay a minimum of 75% for employees, there is no requirement for dependent(s) contribution).

Employee Census

Please include all Eligible Employees; Eligible Employees include all full-time, active employees and owners who have satisfied your company's probationary period for insurance coverage. Please include additional census information if necessary

SEX M/F	DATE of BIRTH	DEPENDENTS Spouse	1CH	2+CH	Total # of Children	SEX M/F	DATE of BIRTH	DEPENDENTS SP	1CH	2+CH	Total # of Children

MBA & BIAW Risk Appraisal Form

Please answer each question to the best of your knowledge for all prospective enrollees including: owners, employees, spouses, dependent children, domestic partners and COBRA participants. This form will not be accepted without all questions being answered. If the answer to any question is "yes," please use the additional space to provide specific information (however, do **NOT** include names or social security numbers).

WELLNESS PROGRAMS

1) Does your company offer wellness programs for your employees? ◯ Yes ◯ No If so, please select all that apply:

☐ **Drug / alcohol screenings** ☐ **On-site flu shots** ☐ **Cholesterol screenings** ☐ **Blood pressure checks**

☐ **Blood glucose screenings** ☐ **Preventive Safety Classes** ☐ **Stop smoking programs** ☐ **Other:**_____

RISK FACTORS

2) Are you aware of any enrollees or prospective enrollees that have been treated, hospitalized or had surgery for a serious illness over the last 12 months? These include, but are not limited to: cancer, AIDS, diabetes, cardiovascular disease, transplant, mental disorders, alcoholism, drug abuse, obesity, etc. ◯ Yes ◯ No

If yes please supply additional information:_____

_____

3) Are you aware of any enrollees or prospective enrollees that have a hospitalization or surgery pending or have been advised that hospitalization or surgery is necessary? ◯ Yes ◯ No

If yes please supply additional information:_____

_____

4) Are you aware of any current or prospective enrollees that are currently disabled or not actively at work because of illness or injury? ◯ Yes ◯ No

5) Are there any prospective enrollees on COBRA continuation coverage? ◯ Yes ◯ No If yes, how many _____

6) Are you aware of any claims that have exceeded $25,000 in the last 12 months on any enrollees or prospective enrollee? ◯ Yes ◯ No

If so please provide an estimate of the amount paid, an explanation of the medical condition, dates, and the likelihood of future claim expenses or ongoing treatment requirements.

_____

_____

_____

7) Are you aware of any enrollees or prospective enrollees with an existing pregnancy? ◯ Yes ◯ No
If "yes" are multiple births expected? ◯ Yes ◯ No

8) Are there any handicapped children who have passed the limiting age and are currently insured? ◯ Yes ◯ No

By completing this form I certify that the above information is correct to the best of my knowledge. This is not an application for coverage. If a contract for coverage is issued and it is determined that false, incorrect, or incomplete information has been provided, and if as a result of correcting the information the Group no longer qualifies for the Rate quoted, I understand that the provider will have the right to adjust the rates. Any group insurance coverage will not be made effective until a proposal is made to the group, an application is completed by the group, and coverage is approved by the MBA/BIAW Trust Carriers.

_____

Name of Individual Completing Form Title Signature

_____

Name of Company Date

Submit Print