

ABC Health Insurance Program Quote Request

If you are a member of the ABC and would like to receive information on the available Health Insurance Plans, complete these forms and fax to:

Sales Consultants
Capital Benefit Services, Inc.
 15375 SE 30th Place, Suite 380, Bellevue, WA 98007

FAX: (425) 643-6728
 PHONE: (800) 545-7011 ext. 6
 EMAIL: sales@epkbenefits.com

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

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 the Associated Builders & Contractors ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide:	Membership ID#	Member Since:
I authorize the MBA Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the MBA Trust.		
Authorized Representative:	Date:	

Current Health Insurance	<input type="checkbox"/> Group Medical <input type="checkbox"/> Group Dental <input type="checkbox"/> Individual Policies <input type="checkbox"/> None				
	CURRENT INSURER _____ TRUST / PROGRAM _____		RENEWAL DATE _____		
	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: _____	
		<u>CURRENT RATES</u>		<u>RENEWAL RATES</u>	
		Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
<i>Employee</i>					
<i>Spouse</i>					
<i>Single Child</i>					
<i>Children</i>					
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).					

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 if your company has 21 or more employees.

	SEX	DATE of BIRTH	DEPENDENTS				SEX	DATE of BIRTH	DEPENDENTS		
	M/F		SP	1CH	2+CH		M/F		SP	1CH	2+CH

PLEASE SEND MY CUSTOM QUOTE VIA EMAIL

(If you are requesting an email response for a quote, please verify your email address at the top of the page)



MBA / BIAW Risk Appraisal Form

Please answer each question to the best of your knowledge for all persons to be insured under your plan including employees, spouses, and dependent children.

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).

1. Are you aware of any employees or dependents that have been treated, hospitalized or had surgery for a serious illness. These include, but are not limited to, cancer, AIDS, diabetes, cardiovascular disease, organ transplant, mental disorders, alcoholism, drug abuse, obesity, etc?

Yes No

2. Are you aware of any employees or dependents that have a hospitalization or surgery pending or have been advised that hospitalization or surgery is necessary?

Yes No

3. Are you aware of any employees or dependents that are currently disabled or not actively at work because of illness or injury?

Yes No

4. Are there any employees or dependents on COBRA continuation coverage?

Yes No

If employees are on COBRA, please describe any major medical situations.

5. Are there any handicapped children who have passed the limiting age and are currently insured?

Yes No

6. Are you aware of any claims that have exceeded \$25,000 in the last 12 months on any insured employee or dependent?

Yes No

If so please provide an estimate of the amount paid, an explanation of the medical condition and the likelihood of future claim expenses (do NOT include names or social security numbers).

7. Are you aware of any employees or covered dependents with an existing pregnancy?

Yes No

If "Yes," are multiple births expected?

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. 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

RA 12/1/05

Upon completion please fax this form to (425) 643-6728