

Request for Group Quote – Medical, Dental, Life

Please complete this form in its entirety, and email to: BenefitOptions@comcast.net

Or print and fax completed form to: 1-866-315-7120 (toll free)

For questions regarding this form, call ☎ 303-914-0159

If current plan design information is not included, we will quote a Standard Plan

Company Information

Company Name _____
Contact Name _____
Address _____
City _____ Colorado ZIP _____
Nature of Business _____ SIC Code _____
Years in Business _____

Employee Information

Total # Employees _____
Total # Eligible Employees _____
Participating Employees _____

Current Plan Design

Medical Carrier _____
Office Copay _____ Prescription _____
Deductible _____ Out-of-pocket _____
Coinsurance _____ Lifetime Max. _____
Type of plan HMO PPO POS EPO Dual Option
Why is group Shopping? Price Benefit Service

Current Rates

Renewal Rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

Please quote the following Carrier(s) and Product(s):

<u>Carrier</u>	<u>Plan Design</u>	<u>Ancillary Products</u>
<input type="checkbox"/> Anthem BC BS	<input type="checkbox"/> HMO	<input type="checkbox"/> Dental
<input type="checkbox"/> Kaiser Permanente	<input type="checkbox"/> PPO	<input type="checkbox"/> Life
<input type="checkbox"/> Aetna	<input type="checkbox"/> POS	<input type="checkbox"/> Vision
<input type="checkbox"/> United Health Care	<input type="checkbox"/> EPO	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Preferred Options:

Office Copay _____ Out-of-pocket _____
Deductible _____ Prescription _____
Coinsurance _____ Lifetime Max. _____

Comments: _____

Employee Census

Company Name _____

#	LAST NAME	FIRST NAME	GENDER	DOB AGE	SPOUSE DOB AGE	# CHILD- REN	HOME ZIP	LIFE AMOUNT	PLEASE SPECIFY HEALTH, LIFE, DENTAL
1			<input type="checkbox"/> M <input type="checkbox"/> F						
2			<input type="checkbox"/> M <input type="checkbox"/> F						
3			<input type="checkbox"/> M <input type="checkbox"/> F						
4			<input type="checkbox"/> M <input type="checkbox"/> F						
5			<input type="checkbox"/> M <input type="checkbox"/> F						
6			<input type="checkbox"/> M <input type="checkbox"/> F						
7			<input type="checkbox"/> M <input type="checkbox"/> F						
8			<input type="checkbox"/> M <input type="checkbox"/> F						
9			<input type="checkbox"/> M <input type="checkbox"/> F						
10			<input type="checkbox"/> M <input type="checkbox"/> F						
11			<input type="checkbox"/> M <input type="checkbox"/> F						
12			<input type="checkbox"/> M <input type="checkbox"/> F						
13			<input type="checkbox"/> M <input type="checkbox"/> F						
14			<input type="checkbox"/> M <input type="checkbox"/> F						
15			<input type="checkbox"/> M <input type="checkbox"/> F						
16			<input type="checkbox"/> M <input type="checkbox"/> F						
17			<input type="checkbox"/> M <input type="checkbox"/> F						
18			<input type="checkbox"/> M <input type="checkbox"/> F						
19			<input type="checkbox"/> M <input type="checkbox"/> F						
20			<input type="checkbox"/> M <input type="checkbox"/> F						

Comments: _____