MBA Health Insurance Program Quote Request

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

Sales Consultants FAX: **(425) 643-6728**

Capital Benefit Services, Inc. PHONE: **(800) 545-7011 ext. 6**

15375 SE 30th Place, Suite 380, Bellevue, WA 98007 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 Master Builders Association of King/Snohomish Counties ? ☐ Yes ☐ 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

☐ Group Medical ☐ Group Dental ☐ Individual Policies ☐ 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:_____

	CURRENT RATES		RENEWAL RATES	
	Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
Employee				
Spouse				
Single Child				
Children				

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 if your company has 21 or more employees.

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

MBA HEALTH INSURANCE TRUST

BIAW HEALTH INSURANCE PROGRAM

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.

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 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 _____

2. Are you aware of any prospective enrollees 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 prospective enrollees that are currently disabled or not actively at work because of illness or injury?

☐ **Yes** ☐ **No**

4. Are there any prospective enrollees on COBRA continuation coverage?

☐ **Yes** ☐ **No**

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 prospective enrollee?

☐ **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 prospective enrollees with an existing pregnancy?

☐ **Yes** ☐ **No**

If "yes," are multiple births (e.g. twins, triplets, etc) 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 9/12/05

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