

PDCA Health Insurance Program Quote Request

If you are a member of the PDCA 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 Painting & Decorating Contractors of America ? <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 |
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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)