NMTA Health Trust

Thank you for your interest in our program.
In order to obtain a quote, our carriers require all sections of this form be completed.

Company Information:

Company Name:	Current Insurer:
Contact Person:	Trust / Program:
Address:	Renewal Date:
City, State, Zip:	How long have you been with your Current Insurer?
Nature of Business:	Are you a member of the Northwest Marine Trade Association?
Phone:	☐ Yes ☐ No
Fax:	If yes, please specify :
Email:	Membership ID# Member Since:

Please verify that you are the current broker of record

Authorized Representative: _____ Date broker of record obtained _____

I authorize the Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the Trust.

Authorized Representative: _____ Date: _____

Please include the following information:

Census - Please include all full-time, active, eligible employees.

Name	Date of Birth	M/F	Dependents Covered (Spouse/Child(ren))	Total # of Children	Waiving Coverage Y/N?	Reason for waiving coverage	Zip Code

Please attach additional census, if necessary

- ☐ **Billing Statement** - Please provide your most recent billing statement.
- ☐ **Current Benefits** - Please provide information on your current employee benefits (medical, dental, vision, life, etc.)
- ☐ **Renewal Information** - If applicable, please provide your renewal rates for the upcoming plan year.
- ☐ **Transition of Care Form** - See back
- ☐ **Claims information** - If available

Please send completed forms to:
Capital Benefit Services, Inc.
15375 SE 30th Place, Suite 380, Bellevue, WA 98007
Phone: (800) 545-7011 ext. 6 / Fax: (425) 643-6728
sales@epkbenefits.com / www.capitalbenefitservices.com

We look forward to serving your company's benefit needs

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).

1. Does your company offer wellness programs for your employees? ◯ **Yes** ◯ **No**
   If so, please check those that apply below:

   ☐ Drug/alcohol screenings ☐ On-site flu shots ☐ Blood pressure checks
   ☐ Blood glucose screenings ☐ Preventive safety classes ☐ Smoke cessation programs
   ☐ Other:_____

2. Are you aware of any enrollees or prospective enrollees who 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 and obesity.)
   ◯ **Yes** ◯ **No**
   If so, please supply additional information: _____

   _____

3. Are you aware of any enrollees or prospective enrollees who have a hospitalization or surgery pending or have been advised that hospitalization or surgery is necessary? ◯ **Yes** ◯ **No**
   If so, 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 so, how many? _____
6. Are you aware of any claims that have exceeded $25,000 in the last 12 months on any enrollees or prospective enrollees? ◯ **Yes** ◯ **No**
   If so, please provide an estimate of the amount paid, an explanation of medical condition, dates and the likelihood of future claim expenses or ongoing treatment requirements:

   _____

   _____

7. Are you aware of enrollees or prospective enrollees with an existing pregnancy? ◯ **Yes** ◯ **No**
   If so, are there 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