# Health Insurance Quote Request Form

CAMPS 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: | Current Broker: |
| Phone: | Are you a member of CAMPS? ◯ Yes ◯ No |
| Fax: | Membership ID# |
| Email: | Member Since: |

How did you hear about the CAMPS Health Trust?

☐ Cold Call ☐ Health Trust Website ☐ Referral ☐ Membership Event ☐ Advertisement ☐ Other (Please Clarify): _____

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 |
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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: (425) 641-8093 / Fax: (425) 643-6728
sales@capitalbenefitservices.com / www.capitalbenefitservices.com

**We look forward to serving your company's benefit needs**

# Transition of Care Questionnaire

Please answer each question, to the best of your knowledge to ensure a smooth transition of care for all prospective enrollees, including: owners, employees, spouses, dependent children, domestic partners and COBRA participants. This form is elective.

**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 ☐ Preventive safety classes
☐ Blood glucose screenings ☐Blood Pressure Checks ☐Smoking cessation programs
☐Other: _____

**2.** Are there any prospective enrollees being treated by specialty providers and/or facilities who would require coordination of care? ☐**Yes** ☐**No**

If so, please specify providers and/or facilities so we may ensure there is no disruption of care:

_____

**3.** Are you aware of any specialty medications utilized by prospective enrollees that would require a prior authorization? ☐**Yes** ☐**No**

If so, please specify medications so we may ensure there is no disruption of care:

_____

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

☐**Yes** ☐**No** If so, how many? _____

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 effective until a proposal is provided, applications are completed by the group and its employees and coverage is approved by the carrier.

_____

Name of Individual Completing Form Title Signature

_____

Name of Company Date