Health Insurance Quote Request Form

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 a trade association? ◯ Yes ◯ No
Fax:	If yes, please specify :
Email:	Membership ID# Member Since:

How did you hear about the MBA/BIAW/NMTA/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

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