

California Quote Request Form

Health Coverage Insurance Services, Inc
 Small Group Sales Support
 Po Box 9417
 Santa Rosa, CA 95405

Fax no.: 800-376-4703
 Phone: 707-509-0106
 E-mail: dennisa@getmymedical.com



FOR INTERNAL USE ONLY	
RSM:	
Rate default:	
UW:	
Quoter:	
E-mail date:	
Fax date:	

EMPLOYER INFORMATION

Group name			Effective date		No. of full-time employees	
Street address (no P.O. box please)				Contact name		
City		State	ZIP code	Fax no.		Phone no.
SIC code	Type of business			Current carrier		

PLEASE CHOOSE PLAN DESIGNS TO QUOTE – Check the applicable box(es) for specific products or “Print All”.

EmployeeElect Health Plan Coverage

<input type="checkbox"/> Premier PPO \$20 Copay/\$250	<input type="checkbox"/> Solution 2500 PPO	<input type="checkbox"/> Lumenos HSA \$2000/100%	<input type="checkbox"/> Classic HMO
<input type="checkbox"/> Premier PPO \$30 Copay/\$500	<input type="checkbox"/> Solution 3500 PPO	<input type="checkbox"/> Lumenos HSA \$3000/100%	<input type="checkbox"/> Saver HMO
<input type="checkbox"/> PPO \$20/\$250	<input type="checkbox"/> Solution 5000 PPO	<input type="checkbox"/> Lumenos HSA \$5000/100%	<input type="checkbox"/> HMO
<input type="checkbox"/> PPO \$30/\$500	<input type="checkbox"/> PPO \$25 Copay GenRx/\$250	<input type="checkbox"/> Lumenos HSA \$1500/80%	<input type="checkbox"/> Select HMO
<input type="checkbox"/> PPO \$40/\$750	<input type="checkbox"/> PPO \$35 Copay GenRx/\$500	<input type="checkbox"/> Lumenos HSA \$2500/80%	
	<input type="checkbox"/> PPO \$45 Copay GenRx/\$750	<input type="checkbox"/> Lumenos HSA \$3500/80%	
<input type="checkbox"/> All products will be quoted in the EmployeeElect portfolio		<input type="checkbox"/> Lumenos HIA Plus \$500/100%	
		<input type="checkbox"/> Lumenos HIA Plus \$750/100%	

Life and Disability Coverage

Group Term Life and AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Group Life (Employer’s choice) <input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No (Salary must be included in census)

Vision Coverage

Yes No

Dental Coverage

Yes No

Please select type of quote requested Composite Age Rated

CENSUS: **Elected Coverage: Employee Only
 Employee + Spouse
 Employee + Child(ren)
 Employee + Family

If you are providing medical conditions in order to obtain a quote, please submit this quote request to the California Broker Sales Support by fax at 800-376-4703 or email dennisa@getmymedical.com.

We will quote Group term life, Vision and Dental if boxes are not marked. Please note that medical groups will be rated by Underwriting as follows:
 Groups size 4 and below = Age rates Group size 5 and above = Composite Rates
 We will send Composite rates in all instances for groups 5 and above, unless a specific request for Age Rates is received.
 For Specialty benefits, minimum levels will be quoted unless a specific amount is requested.

Census *must* include salary amounts if Life or STD is function of salary. Please include additional sheets if necessary. To ensure timely turn-around of your quote request, please check all applicable boxes. Fill out genders and ages/DOB and coverage type requested for each employee.

	Employee Name	Gender	Date of Birth or Age	Elected Coverage**	No. of Children	ZIP Code	Waived/COBRA (if applicable)	Salary (if applicable)
1		<input type="checkbox"/> M <input type="checkbox"/> F						
2		<input type="checkbox"/> M <input type="checkbox"/> F						
3		<input type="checkbox"/> M <input type="checkbox"/> F						
4		<input type="checkbox"/> M <input type="checkbox"/> F						
5		<input type="checkbox"/> M <input type="checkbox"/> F						
6		<input type="checkbox"/> M <input type="checkbox"/> F						
7		<input type="checkbox"/> M <input type="checkbox"/> F						
8		<input type="checkbox"/> M <input type="checkbox"/> F						
9		<input type="checkbox"/> M <input type="checkbox"/> F						
10		<input type="checkbox"/> M <input type="checkbox"/> F						
11		<input type="checkbox"/> M <input type="checkbox"/> F						
12		<input type="checkbox"/> M <input type="checkbox"/> F						
13		<input type="checkbox"/> M <input type="checkbox"/> F						
14		<input type="checkbox"/> M <input type="checkbox"/> F						
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18		<input type="checkbox"/> M <input type="checkbox"/> F						
19		<input type="checkbox"/> M <input type="checkbox"/> F						
20		<input type="checkbox"/> M <input type="checkbox"/> F						
21		<input type="checkbox"/> M <input type="checkbox"/> F						
22		<input type="checkbox"/> M <input type="checkbox"/> F						
23		<input type="checkbox"/> M <input type="checkbox"/> F						
24		<input type="checkbox"/> M <input type="checkbox"/> F						
25		<input type="checkbox"/> M <input type="checkbox"/> F						
26		<input type="checkbox"/> M <input type="checkbox"/> F						
27		<input type="checkbox"/> M <input type="checkbox"/> F						

Are you aware of any medical conditions of which you want UW to be aware? Yes No If more room is needed, please attach a separate sheet.

Emp no.:	
Emp no.:	
Emp no.:	
Emp no.:	