

# 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.**

CC - DP

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fax:	If yes, please specify :
Email:	Membership ID#                      Member Since:

I authorize the Trust Consultants (Pro Benefit Services) 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:**  
Dennis Poppe - Premiere Benefit Services  
335 116th Ave SE, Suite 200, Bellevue, WA 98004  
Phone: (425) 246-0973 / Fax: (425) 643-6728  
sales@epkbenefits.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