|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fill in for a quote | | | | |
| **Account Information** | | | | |
| Company Name: | |  | Effective Date: | |
| Address: | |  | Contract Year Ends: | |
| City: | |  | Fiscal Year Ends: | |
| State: | |  | Plan Year Runs (Calendar Year / Other): | |
| Zip: | |  | SIC Code: | |
| Phone: | |  | Tax ID Number: | |
| Other Locations: | |  | Total # of Employees: | |
| Coverages to Administer: Tier Type: 4 | |  | Total # of Eligible | |
| Individual /Employee & Children/Dual/Family | |  | Total # of Subscribers | |
|  | |  | Total # FTE | |
| **Are you a 1557 covered entity? \_\_\_Yes \_\_\_ No** |  |  | |
| **Broker** |  |  | |
| Broker Agency: |  |  | |
| Name: | |  | Email: | |
| Phone: | |  | Fax: | |
|  | |  |  | |
| Fill in post-sale | | | | |
| **Key Executive** | | | | |
| Name: | |  | Email: | |
| Phone: | |  | Fax: | |
|  | | | | |
| **Contact Person (Eligibility)** | | | | |
| Name (#1): | |  | Email: | |
| Phone: | |  | Fax: | |
| Name (#2): | |  | Email: | |
| Phone: | |  | Fax: | |
| **Contact Person (Funding)** | | | | |
| Name (#1): | |  | Email: | |
| Phone: | |  | Fax: | |
| Name (#2): | |  | Email: | |
| Phone: | |  | Fax: | |
| **Name of Person who will sign Plan Document and Amendments** | | | | |
| Name: | |  |  | |
| **Names of Persons who will have access to view and receive PHI reports** | | | | |
| Names | |  | Job Title |  |
|  | |  |  |  |
|  | |  |  |  |
| Classes /Job Titles with access to view PHI: | | | | |
|  | |  |  |  |
|  | |  |  |  |
|  | |  |  |  |
| **Eligibility** | | | | |
| Enrollment Vendor contact info: | |  | How will eligibility be provided: | |
| Coverages Elected (Independently / Bundled): | |  | Divisions /departments for eligibility and reporting: | |
| Does Group Offer EAP (Yes / No): | |  | How many hours per week for employee full time status? | |
| PT employees eligible (Yes / No): | |  | Hours per week to continue coverage after initial enrollment (if different): | |
| Sect. 125 change in status rules apply (in addition to mandated Special Enrollment rules) (Yes / No): | |  | Separate eligibility for different classes of EE's (Yes / No): | |
| Employee Contribution (Yes / No): | |  | Open Enrollment (Yes / No): | |
| Month open enrollment: | |  | Effective date of coverage: | |
| Waiting Period: Waive Upon (Initial enrollment / Don't waive): | |  | Termination Date: | |
| **Extensions of coverage** | | | | |
| Lay off period: | |  | Other approved leaves of absence (specify): | |
| Non-FMLA Disability leave of absence period: | |  | Compensation maint. /sev. agreement regarding COBRA (runs concurrently / begins after severance ends): | |
| Non-FMLA Medical leave of absence period: | |  |  | |
| **Dependent eligibility** | | | | |
| Will Comply with federal age 26 rule for dependents unless otherwise stated: | |  | Does plan allow civil union coverage (Yes / No): | |
| Other dependent child provision (Yes / No): | |  | Does plan allow ex-civil union coverage (Yes / No): | |
| Does plan allow ex-spouse coverage (Yes / No): | |  | Does plan allow domestic partner coverage (Yes / No): | |
| Does plan allow same sex spouse coverage (Yes / No): | |  | Does plan allow ex-domestic partner coverage (Yes / No): | |
| Does plan allow ex-same sex spouse coverage(Yes / No): | |  | COBRA available to same sex spouses/Domestic partners/Civil union partners (Yes / No): | |

|  |  |  |
| --- | --- | --- |
| **Funding** | | |
| FBO Account Funding (Wire / Check / ACH): |  |  |
| ACH Initiated by: |  |  |
| How monthly fees are paid (Wire / Check / ACH)? |  |  |
| Who should the Monthly Statement go to? |  |  |
|  |  |  |
|  |  |  |
| Names |  | Email |  |
|  |  |  |  |
|  |  |  |  |