

QUOTE REQUEST FORM

PLEASE EMAIL TO YOUR TEAM OR FAX TO US AT 844-547-4329

Today's Date: _____

GROUP INFORMATION

Company Name: _____ City: _____ Zip: _____

Effective Date: _____ SIC Code: _____ # of Union Employees: _____

of FTEs: _____ # of Benefit Eligible: _____

Coverage Provided by a Labor Fund? _____ # of 1099 Employees? _____ # of Out of State Employees? _____

BROKER INFORMATION

Name: _____

Agency Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ Lic.#: _____

Please mark the carriers that you and your agency are currently appointed with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Aetna | <input type="checkbox"/> CCHP | <input type="checkbox"/> Sharp Health Plan |
| <input type="checkbox"/> Anthem Blue Cross | <input type="checkbox"/> Covered CA SHOP | <input type="checkbox"/> Sutter Health Plus |
| <input type="checkbox"/> Blue Shield | <input type="checkbox"/> Health Net | <input type="checkbox"/> UnitedHealthcare |
| <input type="checkbox"/> CaliforniaChoice® | <input type="checkbox"/> Kaiser Permanente® | <input type="checkbox"/> Western Health Advantage |
| <input type="checkbox"/> CalCPA | <input type="checkbox"/> MediExcel | |

MEDICAL	DENTAL	OTHER
<input type="checkbox"/> Aetna <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> CaliforniaChoice® <input type="checkbox"/> CalCPA (SIC 8721) <input type="checkbox"/> CCHP <input type="checkbox"/> Covered California <input type="checkbox"/> Health Net <input type="checkbox"/> Kaiser Permanente® <input type="checkbox"/> MediExcel <input type="checkbox"/> Sharp Health Plan <input type="checkbox"/> Sutter Health Plus <input type="checkbox"/> UnitedHealthcare <input type="checkbox"/> Western Health Advantage	<input type="checkbox"/> Aetna <input type="checkbox"/> Ameritas <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> California Dental <input type="checkbox"/> Choice Builder <input type="checkbox"/> CoPower Delta Dental <input type="checkbox"/> Delta Dental <input type="checkbox"/> LifeMap <input type="checkbox"/> MetLife <input type="checkbox"/> Premier Access <input type="checkbox"/> Principal Life <input type="checkbox"/> Reliance <input type="checkbox"/> UnitedHealthcare <input type="checkbox"/> Unum	<input type="checkbox"/> Life <input type="checkbox"/> Flat <input type="checkbox"/> X Salary <input type="checkbox"/> Class <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Call a Doctor Plus <input type="checkbox"/> Chiro/Acu <input type="checkbox"/> CoPower ONE
<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HSA <input type="checkbox"/> ALL	<input type="checkbox"/> DHMO <input type="checkbox"/> DPO <input type="checkbox"/> Indemnity <input type="checkbox"/> ALL	

QUOTE DELIVERY	ADDITIONAL NOTES
Needed by (date): _____ <input type="checkbox"/> Hold for Pick-up DATE: _____ TIME: _____ <input type="checkbox"/> Email <input type="checkbox"/> Fax (Summaries Only)	_____ _____ _____

Do you have current coverage? If yes, please provide the name of your plan(s) below or a copy of your renewal

Yes No

Carrier & Plan Name(s)



