

A Health Insurance Shoppe

Group Quote Request

Group Information	Broker Information
Name	Name Sam Schoppenhorst/A Insurance Shoppe
Address	Phone 520-318-4800
Address	Fax 520-318-9400
City St Zip	Email sam@123411.com
Web Address	www.123411.com

Requested Benefits				Ancillary Only <input type="checkbox"/>			
Medical		Out of Pocket	Dental	Ancillary			
Plan	Deductible			Plan	Group	Voluntary	
<input type="checkbox"/> HMO	<input type="checkbox"/> \$250	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	Indemnity <input type="checkbox"/>	Vision <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PPO	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,500		PPO <input type="checkbox"/>	STD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> POS	<input type="checkbox"/> \$750	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$10,000	DMO <input type="checkbox"/>	LTD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HSA	<input type="checkbox"/> \$1,000	<input type="checkbox"/> HSA		Voluntary <input type="checkbox"/>	Life \$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Specific Carriers Requested: _____

Current Information

Number of Employees	Employer Contribution %	Renewal Date	Employees in
Total	EE	Current	Arizona <input type="checkbox"/>
Eligible	Dependents	Desired	Out of State <input type="checkbox"/>
Participating			# of Locations _____
Cobra (included in totals)	Nature of Business	SIC Code	Yrs in Business
Carve Out Y N	Current Carrier		Yrs with Carrier
Waiting Period	Previous Carrier		Yrs with Carrier

Current Rates	Medical				Dental		Vision		Other	
	HMO		PPO/POS/HSA		Current	Renewal	Current	Renewal	Current	Renewal
	Current	Renewal	Current	Renewal						
EE										
EE/SP										
EE/CH										
EE/SP/CH										

Current Benefits	Medical		Dental		Ancillary
	HMO	PPO/POS			
Phys Co-Pay			Deductible		Life/AD&D <input type="checkbox"/>
Deductible			Plan Design		Amount \$ _____
Co Ins			Calendar Yr Max		Dep Life <input type="checkbox"/>
OOP Max			Ortho Included		Vision <input type="checkbox"/>
Family Max					STD <input type="checkbox"/>
RX Co-pay					LTD <input type="checkbox"/>
Hosp Co-pay					Sec 125 <input type="checkbox"/>

If you are aware of any employees in your group who has one of the conditions listed below, please mark accordingly.

Arthritis <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Kidney Disorder <input type="checkbox"/>	Open Hrt Surg <input type="checkbox"/>	Alcohol or Drug Abuse <input type="checkbox"/>
Back/Neck <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Lung Disorder <input type="checkbox"/>	Organ Transplt <input type="checkbox"/>	Other <input type="checkbox"/>
Cancer <input type="checkbox"/>	Heart Disorder <input type="checkbox"/>	Lupus <input type="checkbox"/>	Pregnancies <input type="checkbox"/>	_____ <input type="checkbox"/>
Cardiac Tests <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>	MD <input type="checkbox"/>	Psych Disorder <input type="checkbox"/>	_____ <input type="checkbox"/>
Crohns Disease <input type="checkbox"/>	Hypertension <input type="checkbox"/>	MS <input type="checkbox"/>	Stroke <input type="checkbox"/>	_____ <input type="checkbox"/>

IN ADDITION, each employee and dependent enrolling for health coverage (including COBRA) should complete a health history form

A Health Insurance Shoppe	Fax	E-mail	Website
520-318-4800	520-318-9400	info@123411.com	www.123411.com

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Census

t. 520-318-4800

f. 520-318-9400

	Gender (M) or (F)	DOB	Coverage Requested					Spouse Age	# of CH	Home Zip Code	Home State	***Occupation	***Monthly Salary	On COBRA
			EE only	EE + SP	EE + CH	EE + FM	WV*							
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***WV** = Eligible employees who are waiving coverage
 ****NC** = Not eligible for coverage (i.e. part time or waiting for enrollment)
 *** = Salary and Occupation are only needed for Disability Quote.