

Claremont Sales Representative: \_\_\_\_\_

Date Needed: \_\_\_\_\_

*Please provide a copy of current benefit summaries.*

**Broker Information**

Broker Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Broker License: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Broker of Record?  Yes  No

**Group Information**

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DBA: \_\_\_\_\_

Nature of Business: \_\_\_\_\_ SIC: \_\_\_\_\_

Number of Years in Business: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Number of Eligible Employees: \_\_\_\_\_ Waiting Period: \_\_\_\_\_

Number of COBRA Participants (indicate on census): \_\_\_\_\_

**Medical Information**

**5 Year Carrier History**

Carrier Name	Type of Coverage	Period Insured or Number of Years

Employer Contribution *		
	HMO	PPO
Employee	0%	0%
Dependents	0%	0%

\*Minimum Employer Contribution is 75%. If age is banded, please provide billing statement.

	Current Rates		Renewal Rates	
EE	HMO	PPO	HMO	PPO
EE/SP				
EE/CH				
FAM				

## Carriers and Plans to be Quoted

**Plans to be quoted:** Blue Shield 51+  California CHOICE 51-199

**Medical:** HMO  PPO  HSA  HMO/PPO

**Rate Tier Requested:**

**Life:** Amount: \_\_\_\_\_ Basis: \_\_\_\_\_

**Dental:**

Current Carrier: \_\_\_\_\_

Current Benefits: \_\_\_\_\_

Current/Renewal Rates: \_\_\_\_\_

Requested Benefits: \_\_\_\_\_

**Vision:**

Current Carrier: \_\_\_\_\_

Current Benefits: \_\_\_\_\_

Current/Renewal Rates: \_\_\_\_\_

Requested Benefits: \_\_\_\_\_

**STD/LTD:**

Current Carrier: \_\_\_\_\_

Current Benefits: \_\_\_\_\_

Current/Renewal Rates: \_\_\_\_\_

Requested Benefits: \_\_\_\_\_

## Health Questions

1. Has any insured received medical benefits in excess of \$15,000 in the last 12 months?  
If **YES**, please provide details: \_\_\_\_\_
2. Are there any disabled participants?  
If **YES**, please provide #: \_\_\_\_\_
3. Are there any catastrophic or other serious medical conditions, pregnancies, or coverage of members not actively at work or currently hospital-confined?  
If **YES**, please provide details: \_\_\_\_\_  
Number of pregnancies: \_\_\_\_\_
4. Are all employees covered by workers' compensation insurance?  
If **NO**, please provide # not covered: \_\_\_\_\_
5. Has any owner or principal filed bankruptcy within the past seven (7) years, or known to be planning to file bankruptcy?
6. Does the employer reimburse employees for any part of their normal out-of-pocket costs (copays, deductibles, coinsurance, etc)?  
*The group may not self-insure any part of the employees normal out-of-pocket costs or provide any type of "GAP Insurance."*
7. Reason for shopping:  
Market check  Unhappy with rates  Unhappy with benefits   
Other: \_\_\_\_\_

**Large Group Census Information**

Gender	Age or Date of Birth	Zip code	Tier Level	Coverage Type	Carrier	COBRA (Y/N)
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