

Legal Name: PHA Group Benefit Trust
Version: PHBT / RFQ_FastTrack / 0308

e: benefits@physicianshealth.org
t: (866) 337.8088
f: (775) 337.8099

Enrollment Representative:

FAST TRACK - REQUEST FOR QUOTE

So that we can provide you with the most competitive quotes, please provide the following information.

SECTION I. GENERAL INFORMATION

Group Name:	_____			Date:	_____		
Address:	_____		City:	State:	Zip Code:		
Contact Person:	Phone:	Fax:	Email:				

SECTION II. GROUP INFORMATION

- No. of employees: *Full Time _____ Part Time _____ *Hours required for full-time status _____
- Current Participants: Full Time _____ Part Time _____ COBRA _____ Other _____
- Waiting period for new employees: First day of the month following _____ days of employment.
- Employer Contributions: _____% of employee _____% of employee dependents

SECTION III. CURRENT COVERAGE (Please attach a copy of your current Schedule of Benefits)

- Current Providers

Medical:	_____	No. Years:	_____
Dental:	_____	No. Years:	_____
Vision:	_____	No. Years:	_____
- Renewal Date: _____
- Projected Effective Date: _____
- Type of Plan: PPO HMO Other _____
- Prescription Drug Coverage

Deductible: \$	_____
Co-payments: \$	_____ Generic \$ _____ Formulary \$ _____ Non-Formulary
- Has coverage ever been non-renewed? Yes No If yes, please explain _____
- Is your coverage: Fully Insured Partially Self-funded

8. Insurer and Rate History: (Please attach a copy of current invoice)

Year:	Current Year	1st Prior Year	2nd Prior Year
Insurer:			
Employee:	\$	\$	\$
Employee & Spouse:	\$	\$	\$
Employee & Child(ren):	\$	\$	\$
Employee & Family:	\$	\$	\$

9. Have your benefits changed in any year listed above? Yes No

If yes, please include a copy of the change and note the year changed.

The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. This is not an application for coverage. Any group coverage will not be made effective until a proposal is made to the group, an application is completed by the group, and coverage is approved by Underwriting.

This form must be completed by an individual within your company who knows, or can obtain the information requested. An officer of the company must certify, to the best of that officer's knowledge, that the information provided is true and accurate.

Applicant's Signature: _____

Date: _____

Title: _____

