

## Quote Request Information

### Marketing locations:

Seattle sales 521 Wall St. Seattle, WA 98121 206-448-4140 1-800-542-6312 Fax 206-448-4271	Tacoma sales 950 Pacific Ave., #900 Tacoma, WA 98402 253-383-6226 1-800-854-5322 Fax 253-383-7825	Central Washington sales 1009 Center Parkway Kennewick, WA 99336 509-783-3484 1-800-458-5450 Fax 509-736-1910	Eastern Washington/ Northern Idaho sales 5615 W Sunset Highway Spokane, WA 99224 509-459-9100 1-800-497-2210 Fax 509-459-1080
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Date \_\_\_\_\_ Group name \_\_\_\_\_

Group address \_\_\_\_\_

List other locations \_\_\_\_\_

Broker/consultant name \_\_\_\_\_

Broker commission percentage rate \_\_\_\_\_

Years in business \_\_\_\_\_ SIC code \_\_\_\_\_

Union? Yes  What % \_\_\_\_\_  
 No

Description of business \_\_\_\_\_

Is the group a subsidiary or part of a national account? \_\_\_\_\_

List current carriers 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Current rating/funding \_\_\_\_\_

Community \_\_\_\_\_

Fully insured \_\_\_\_\_

Retention \_\_\_\_\_

Minimum premium \_\_\_\_\_

Cost plus \_\_\_\_\_

Self-funded \_\_\_\_\_

Other \_\_\_\_\_

Number of employees covered under each current plan \_\_\_\_\_

Employer contribution: \_\_\_\_\_

Employee (% or \$) \_\_\_\_\_

Dependent (% or \$) \_\_\_\_\_

Current anniversary date \_\_\_\_\_ Proposed effective date \_\_\_\_\_ Guaranteed to \_\_\_\_\_

Total replace? Yes  No  Date quote needed \_\_\_\_\_

If no, list other carriers to be offered \_\_\_\_\_

Number of eligible employees \_\_\_\_\_ Number of COBRA employees \_\_\_\_\_ (over)

Definition of a "covered employee" \_\_\_\_\_

Probation: number of days \_\_\_\_\_

Seasonal employees: Yes  No  Number of seasonal employees \_\_\_\_\_

If yes, describe \_\_\_\_\_

Other anticipated changes in number of eligibles? Yes  No

If yes, describe \_\_\_\_\_

Rate history (last three years)

Carrier name	From	To	Emp. or Composite	Rate category (please indicate spouse, first child, second child, children on lines below)			
1. _____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Current benefits (including deductibles, coinsurance, copayments, and stop loss, or attach a copy of current benefits).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any catastrophic claims? Yes  No

Please attach 1 to 2 years of your most recent claims experience. If this is not available, complete the attached Risk Appraisal Form.

Are there any employees currently disabled or not at work? Yes  No

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Please check appropriate box below:

- Please attach census including spouses and dependents. (Please include sex, date of birth, zip code, number of children enrolled, and whether spouse is to be covered.)
- For all groups not providing two years of paid claim history, please fill out and sign the attached risk appraisal form.
- For large groups for which experience is available, please provide two years' paid claim history.

# Risk Appraisal Form

This questionnaire is designed to assist us in obtaining information necessary to evaluate your group. Please answer the questions to the best of your knowledge for the persons to be insured—employees, spouses, and dependent children.

If the answer to any of the following questions is “yes,” please use the additional space provided to explain.

1. Are you aware of any employee or dependent who has been treated, hospitalized or had surgery for a serious illness, physical or mental disorder, including but not limited to, cancer, AIDS, diabetes, cardiovascular disease, organ transplant, alcoholism, drug abuse, obesity, etc.?

No

Yes  \_\_\_\_\_

2. Are you aware of any employee or dependent who has hospitalization or surgery pending or has been advised that hospitalization or surgery is necessary?

No

Yes  \_\_\_\_\_

3. Are you aware of any employee or dependent who is currently disabled or not actively at work because of illness or injury?

No

Yes  \_\_\_\_\_

4. Are there any employees or dependents on COBRA continuation or any handicapped children who have passed the limiting age and are currently insured by the present carrier?

If employees are on COBRA, please describe any major medical situations on the reverse side.

No

Yes  \_\_\_\_\_

5. Please list on the reverse side any claims you are aware of that have exceeded \$5,000 in the last 12 months on any insured employee or dependent. Please provide an estimate of the amount paid, an explanation of the medical condition and the likelihood of future claim expenses.

No

Yes  \_\_\_\_\_

6. Are there any employees or dependents with an existing pregnancy?

No

Yes  \_\_\_\_\_

If “yes,” are multiple births expected?

No

Yes  \_\_\_\_\_

**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 insurance 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 Group Health Cooperative or Group Health Options, Inc.**

Prospective Applicant Name

Title

Signature

Name of Company

Date

