



Legal Name: The Evangelical Benefit Trust
Version: EBT / RFQ / 0409

Submit to:
Benefit Services
PO Box 950
Forest Hill, MD 21050

p 866.902.6227
f 866.903.6227

Adobe Reader Version 7 or later is required to complete this form. Download the FREE update at www.adobe.com

REQUEST FOR QUOTE

So that we may provide you with the most competitive quotes, please complete this fillable form. Then save it, print it, sign it and fax it back to the number shown above.

SECTION I. GENERAL INFORMATION

Company Name: _____ Date: _____ (mm/dd/yyyy)
Street Address: _____
City: _____ State: _____ Zip: _____
Administrative Contact: _____ Title: _____
Telephone: _____ Fax: _____ E-mail: _____

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: _____ (mm/dd/yyyy)
- Projected Effective Date: _____ (mm/dd/yyyy)
- 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)

	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.

SECTION IV. MEDICAL INFORMATION

This section 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 and if necessary, an additional sheet if needed to explain.

- 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 _____
- Are you aware of any employee or dependent who has a hospitalization or surgery pending or has been advised that hospitalization or surgery is necessary?
No
Yes _____
- Are you aware of any employee or dependent who is currently disabled or not actively at work because of illness or injury?
No
Yes _____
- Are there any employees or dependents on COBRA? If yes, please describe any major medical situations, the qualifying event and the date of the qualifying event.
No
Yes _____
- Are there any employees or dependents with an existing pregnancy?
No
Yes _____
- If "yes," are multiple births expected?
No
Yes _____
- Are there any handicapped children who have passed the limiting age and are currently insured by the present carrier?
No
Yes _____

8. Please list below 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.

Estimated Amount	Explanation
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	

SECTION V. ATTACHMENTS

Please also include the following information:

- Complete employee census (see page 4 or attach a separate list)
- Copy of your most recent bill
- Copy of your benefit book or summary plan description

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.

Today's Date: _____ (mm/dd/yyyy)

Officer / Director Printed Name: _____ Title: _____

Officer / Director Signature: _____

COMPANY CENSUS REPORT

Please include all Full Time Employees on this census. For Employees in their waiting period, please indicate their date of hire following the Employee Name.

	Employee Name	If Waiving		DOB	M/F		Zip Code	Class
		REASON:		MM/DD/YYYY	CLICK		FIVE DIGITS	EE, EE + S, EE + CHILDREN, EE + FAMILY
		<small>OTHER COVERAGE</small>	<small>NO COVERAGE</small>		<small>M</small>	<small>OR</small>		
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