# *QUOTE REQUEST*

***Completed By / Contact:_____________________________________________________***

***Phone Number_________________________Email_______________________________***

*Legal name of Company_________________________________Effective Date_____________*

*City_________________________State_______Zip____________*

*Are there multiple locations? _______*

*Nature of Business_________________________________________SIC Code________________*

*Preferred Network / Hospital Affiliate:_____________________________*

***Current Coverage:***

*Type of Plan: ____Fully Insured ____Self-Funded ____Min. Premium*

*Carrier and/or Third Party Administrator:__________________________________________*

*If self funded, contract basis:_________________*

*Employer contribution: Employee______% Dependents______%*

***Requested Coverage:***

***Specific:***

*Annual Deductible Amount $_____________________*

*Basis of Coverage*

- *____ 12/12: Incurred and paid within the policy period*
- *____15/12: Incurred within the policy period or 90 days immediately prior and within policy period*
- *____12/15: Incurred within the policy period and paid within the policy period or 90 days immediately thereafter .*
- *____Other________________________________________________________*

***Aggregate:***

*Basis of Coverage*

- *____ 12/12: Incurred and paid within the policy period*
- *____15/12: Incurred within the policy period or 90 days immediately prior and within policy period*
- *____12/15: Incurred within the policy period and paid within the policy period or 90 days immediately thereafter.*
- *____Other________________________________________________________*

*Options: ____Aggregate Accommodation ____Terminal Extension*

***Benefits:***

| | *Yes* | *No* |
|---|---|---|
| *Medical* | ____ | ____ |
| *Prescription Drug Card* | ____ | ____ |
| *Dental* | _____ | _____ |
| *Vision* | ____ | ____ |
| *Short Term Disability* | ____ | ____ |

***Current Enrollment:***

*Total Number of Employees Eligible:_____________*

*Total Number of Employees Participating:_________*

*Coverage Count:*

_____*Employee*

_____*Employee / Spouse*

_____Employee / Child(ren)

_____*Family*

***Rates and Factors:***

| | *Rates* | | *Fully Insured Rates OR Aggregate Factors* | | |
|---|---|---|---|---|---|
| | *Specific* | *Aggregate* | *Medical* | *Rx Card* | *Dental* |
| *Current* | | | | | |
| Employee | ______ | ______ | _______ | _______ | _______ |
| *EE / SP* | ______ | ______ | _______ | _______ | _______ |
| *EE / CH* | ______ | ______ | ____________________ | | |
| *Family* | ______ | ______ | ____________________ | | |
| *Renewal* | | | | | |
| *Employee* | ______ | ______ | ____________________ | | |
| *EE / SP* | ______ | ______ | ____________________ | | |
| *EE / CH* | ______ | ______ | ____________________ | | |
| *Family* | ______ | ______ | ____________________ | | |

***In order to process a quote we will need the following items:***

- ***Current Plan Document noting any changes you would like made***
- ***A current census stating age, sex, and coverage status. (and location if applicable)***
- ***Claims experience for the past 3 years preferred (minimum of 2 years)***
- ***Any medical claim(s) exceeding 50% of requested specific deductible***

**Upon completion, please mail this form and the items listed above to:**

**Attn: Customer Service**
**FirstChoice Administrators**
**P.O. Box 10704**
**Springfield, MO 65808**