Download http://get.adobe.com/reader/ and open Request for Quote with Acrobat Reader, enter data in fillable form, then save and submit.

101+ CENSUS & REQUEST FOR QUOTE

Submit Completed Census to your dedicated Account Executive or submit by email to sales@dickerson-group.com

License #0M29112

Broker Information ✔

Date: ______________________

Broker Firm Name: ______________________

Producer Name: ______________________

Broker Address: ______________________

City: ______________________

State: __________ ZIP Code: __________

Phone: __________ Fax: __________

Email: ______________________

Broker of Record? ☐ Yes ☐ No

Group Information ✔

Company/Group Name: ______________________

Address: ______________________

City: ______________________

State: __________ ZIP Code: __________

DBA: __________ Phone: __________

Nature of Business: ______________________

SIC Code: __________ Years in Business: __________

Effective Date: __________ Waiting Period: __________

(non-COBRA) Eligible Employees: __________

COBRA Employees: __________

Common ownership with other companies? ☐ Yes ☐ No

Medical Information ✔ 5-Year Carrier History

	Carrier Name	Type of Coverage	Period Insured or # of Years
1			
2			
3			
4			
5			

If Kaiser is Present: ☐ Kaiser Will Remain ☐ Total Replacement

Employer Contribution Amount: HMO

per Employee: __________

per Dependent: __________

Employer Contribution Amount: PPO

per Employee: __________

per Dependent: __________

Current Rates ✔

If age banded, please attach billing statement.

	HMO	PPO	Kaiser
EE			
EE/SP			
EE/CH			
FAM			

Renewal Rates ✔

Please attach complete renewal, including large claims report. (If renewal is not available, please attach current carrier bill.)

	HMO	PPO	Kaiser
EE			
EE/SP			
EE/CH			
FAM			

Current Benefits Description ✔

Please attach benefit summary(ies).

Carriers to be Quoted

☐	☐	☐	☐	☐	☐
Aetna	**Anthem Blue Cross**	**Blue Shield**	**Cigna**	**Health Net**	**United HealthCare**
Call for details	Call for details	Call for details	Call for details	101-500	Call for details

Plans to be Quoted

Medical: ☐ **HMO** ☐ **PPO** ☐ **HSA** ☐ **POS**

☐ ***Life:*** Amount: ______________________ Basis: ______________________

☐ ***Dental:*** Current Dental Carrier: ______________________

Current Benefits: ***Please attach benefit summary(ies)***

Current Dental Rates: ______________________

Requested Dental Benefits: ______________________

☐ ***Vision:*** Current Vision Carrier: ______________________

Current Benefits: ***Please attach benefit summary(ies)***

Current Vision Rates: ______________________

Requested Vision Benefits: ______________________

☐ ***STD/LTD:*** Current DI Carrier(s): ______________________

Current Benefits: ***Please attach benefit summary(ies)***

Current DI Rates: ______________________

Requested DI Benefits: ______________________

Health Questions *Yes/No*

1. Has any insured received medical benefits in excess of $15,000 in the last 12 months? __________
   Provide details if **YES**: ______________________
2. Are there any disabled participants? __________
   Provide # of disabled participants if **YES**: __________
3. Are there any catastrophic or other serious medical conditions, pregnancies, or coverage of members not actively at work, or currently hospital-confined? __________
   Provide details if **YES**: ______________________
   Provide # of pregnancies: __________
4. Are all employees covered by workers' compensation insurance? __________
   Provide # of employees not covered if **NO**: __________
5. Has any owner or principal filed bankruptcy within the past seven 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.)

Note: The group may not self-insure any part of the employees' normal out-of-pocket costs or provide any type of "GAP Insurance."

Reason for shopping: (mark all that apply) ☐ Market Check ☐ Unhappy with Rates ☐ Unhappy with Benefits

Other: ______________________

____