

Group Information Form

Group Information

GROUP NAME

STREET

CITY

STATE

ZIP

NATURE OF BUSINESS

CURRENT CARRIER

EFFECTIVE/RENEWAL DATE

Did you attach a copy of the current bill? yes no

Current Benefits

(This does not need to be completed if you attach a benefit summary)

Number of Plan(s) Offered?

Type of Plan(s) Offered? HMO POS PPO

Plan 1

PCP Co-pay _____ Spec. Co-pay _____ In-Net Deductible _____ / _____ Out-Net Deductible _____ / _____
In-Net coinsurance _____ % Out-Net coinsurance _____ % Rx Co-pay _____ / _____

Plan 2

PCP Co-pay _____ Spec. Co-pay _____ In-Net Deductible _____ / _____ Out-Net Deductible _____ / _____
In-Net coinsurance _____ % Out-Net coinsurance _____ % Rx Co-pay _____ / _____

Plan 3

PCP Co-pay _____ Spec. Co-pay _____ In-Net Deductible _____ / _____ Out-Net Deductible _____ / _____
In-Net coinsurance _____ % Out-Net coinsurance _____ % Rx Co-pay _____ / _____

Census

(Please attach an Excel spreadsheet with the following employee information)

1. Gender
2. Date of Birth
3. Home Zip Code
4. Coverage Status
5. Spouse Date of Birth
6. # of Children
7. Salary (If quoting Life/or Disability)
8. Job Title (If quoting Life/or Disability)