DiBuduo DeFendis
INSURANCE BROKERS, LLC

LARGE GROUP QUOTE REQUEST

Requested Effective Date:				
Employer Group Name:				
Address:		**City:**		**Zip:**
Nature of Business:				
# Eligible Employees:		**# Enrolled Employees:**		
Probationary Period: Date of Hire:	**30 Days:**	**60 Days:**	**90 Days: 180 Days:**	**Other:**
Employer Contribution: $ or %	**Employee:**		**Dependent:**	

CARRIER INFORMATION – 5 Year History Required

Current Carrier:			**# of Years:**	
Prior Carrier:			**# of Years:**	
Kaiser In-force: Y N				
Will Kaiser Remain In-Force?		**Yes:**	**No:**	
Current Rates:	**HMO EMP:**	**EMP/SP:**	**EMP/CH:**	**FAM:**
Current Rates:	**PPO EMP:**	**EMP/SP:**	**EMP/CH:**	**FAM:**
Renewal Rates:	**HMO EMP:**	**EMP/SP:**	**EMP/CH:**	**FAM:**
Renewal Rates:	**PPO EMP:**	**EMP/SP:**	**EMP/CH:**	**FAM:**

UNDERWRITING INFORMATION

Please answer the following questions to the best of your knowledge on behalf of all proposed insureds (eligible employees and their eligible dependents, retirees, continuees on COBRA or other continuation; and individuals who are eligible for, but have not yet elected, COBRA or another continuation program). If you need additional space, please check here ☐ and attach a separate sheet.

QUESTION 1: COVERAGE CONTINUATION – PLEASE ANSWER FOR ALL PROPOSED INSUREDS.

A) How many are currently on extension/continuation of benefits under COBRA
☐ None ☐_____- Complete table below.

Proposed Insured	Age	Gender	Employee or Dependent	Date Continuation Began	Qualifying Event
		☐M ☐F	☐E ☐D	/ /	
		☐M ☐F	☐E ☐D	/ /	
		☐M ☐F	☐E ☐D	/ /	

B) How may retired employees are covered under the group plan? If they are covered, please provide details on a separate sheet.
☐ None ☐_____

QUESTION 2: TREATMENT & CONDITION INFORMATION

Please answer the following questions to the best of your knowledge for the persons to be insured (employees, dependents, partners) Provide details to any YES answers:	**Yes / No**
A) Are you aware of any person that is disabled, or being treated for heart disease, stroke, cancer, kidney disorder, AIDS or AIDS related complex, chronic respiratory disease, or is currently hospitalized or has been told extensive medical treatment, surgery or hospitalization is required? A1) In the past 12 months, has any eligible enrollee been hospitalized?	☐ Y ☐ N ☐ Y ☐ N
B) In the past twelve months, has anyone suffered a condition that resulted in expense of $25,000 or more?	☐ Y ☐ N
C) Who is currently pregnant?	☐ Y ☐ N
D) Anyone on leave of absence	☐ Y ☐ N
E) **FOR BLUE CROSS ONLY** – Has any insured received medical benefits in excess of $50,000 in the last 12 months	☐ Y ☐ N

IF YOU ANSWERED "YES" TO ANY QUESTIONS ABOVE, PLEASE PROVIDE DETAILS BELOW:							
Employee or Dependant	**Gender**	**Age**	**Nature of Illness or Injury**	**Dates of Treatment**	**Claim Dollars Spent**	**Current Health Status**	**Current Enrollment**
☐ E ☐ D	☐ M ☐ F			/ /			☐ HMO ☐ PPO
☐ E ☐ D	☐ M ☐ F			/ /			☐ HMO ☐ PPO
☐ E ☐ D	☐ M ☐ F			/ /			☐ HMO ☐ PPO
☐ E ☐ D	☐ M ☐ F			/ /			☐ HMO ☐ PPO

By my signature, I certify to the **best of my knowledge** that the answers to the above questions are complete and correct. I have received written authorization from the Employer (Covered Insured(s)) to market on their behalf and share any PHI as it relates to normal business practice in reviewing their health coverage (employee benefits – heath, dental, LTD, STD, life). I understand that final rates and acceptance of the group are based in part on this information.

Signatures

Name of Broker:

Broker of Record: **Y:** **N:**

Commissions: Standard **Non-Standard-Please Indicate:**

Broker Signature: **Date:**