|  |
| --- |
| Fill in for a quote |
| **Account Information** |
| Company Name:  |  | Effective Date: |
| Address: |   | Contract Year Ends: |
| City:  |   | Fiscal Year Ends: |
| State: |   | Plan Year Runs (Calendar Year / Other): |
| Zip:  |   | SIC Code: |
| Phone: |   | Tax ID Number:  |
| Other Locations: |   | Total # of Employees: |
| Coverages to Administer: Tier Type: 4 |  | Total # of Eligible |
| Individual /Employee & Children/Dual/Family |  | Total # of Subscribers |
|  |   | Total # FTE |
| **Are you a 1557 covered entity? \_\_\_Yes \_\_\_ No** |  |  |
| **Broker** |  |  |
| Broker Agency: |  |  |
|  Name:  |   | Email:  |
|  Phone:  |   | Fax: |
|  |  |  |
| Fill in post-sale |
| **Key Executive**  |
| Name:  |   | Email:  |
| Phone:  |   | Fax: |
|  |
| **Contact Person (Eligibility)**  |
| Name (#1):  |   | Email:  |
| Phone: |   | Fax: |
| Name (#2): |   | Email:  |
| Phone:  |   | Fax: |
| **Contact Person (Funding)**  |
| Name (#1):  |   | Email:  |
| Phone: |   | Fax: |
| Name (#2): |   | Email:  |
| Phone:  |   | Fax: |
| **Name of Person who will sign Plan Document and Amendments**  |
| Name: |  |  |
| **Names of Persons who will have access to view and receive PHI reports** |
| Names |  | Job Title |  |
|  |  |  |  |
|  |  |  |  |
| Classes /Job Titles with access to view PHI: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Eligibility** |
| Enrollment Vendor contact info: |   | How will eligibility be provided: |
| Coverages Elected (Independently / Bundled):  |   |  Divisions /departments for eligibility and reporting: |
| Does Group Offer EAP (Yes / No):  |   |  How many hours per week for employee full time status? |
| PT employees eligible (Yes / No): |  | Hours per week to continue coverage after initial enrollment (if different): |
| Sect. 125 change in status rules apply (in addition to mandated Special Enrollment rules) (Yes / No):  |  | Separate eligibility for different classes of EE's (Yes / No):  |
| Employee Contribution (Yes / No): |  | Open Enrollment (Yes / No): |
| Month open enrollment: |  | Effective date of coverage: |
| Waiting Period: Waive Upon (Initial enrollment / Don't waive):  |  | Termination Date: |
| **Extensions of coverage** |
| Lay off period: |   | Other approved leaves of absence (specify):  |
| Non-FMLA Disability leave of absence period:  |   | Compensation maint. /sev. agreement regarding COBRA (runs concurrently / begins after severance ends):  |
| Non-FMLA Medical leave of absence period: |  |  |
| **Dependent eligibility**  |
| Will Comply with federal age 26 rule for dependents unless otherwise stated:  |  | Does plan allow civil union coverage (Yes / No):  |
| Other dependent child provision (Yes / No):  |   | Does plan allow ex-civil union coverage (Yes / No):  |
| Does plan allow ex-spouse coverage (Yes / No):  |   | Does plan allow domestic partner coverage (Yes / No):  |
| Does plan allow same sex spouse coverage (Yes / No):  |   | Does plan allow ex-domestic partner coverage (Yes / No): |
| Does plan allow ex-same sex spouse coverage(Yes / No): |  | COBRA available to same sex spouses/Domestic partners/Civil union partners (Yes / No):  |

|  |
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| **Funding** |
| FBO Account Funding (Wire / Check / ACH):  |   |  |
|  ACH Initiated by:  |  |  |
| How monthly fees are paid (Wire / Check / ACH)?  |  |  |
| Who should the Monthly Statement go to? |   |  |
|  |  |  |
|  |  |  |
| Names |  | Email |  |
|  |  |  |  |
|  |  |  |  |