

Health Insurance Quote Request Form



Send your completed forms to: Pro Benefits of Washington

▪ info@probenefitswa.com ▪ 425.643.3350 ▪ probenefitswa.com

IF YOU CURRENTLY OFFER GROUP COVERAGE, please provide the following information to allow our team to deliver a more accurate and tailored financial proposal for you:

- Most recent **billing statement**
- **Benefit summaries** (current and renewal)
- **Rates** (current and renewal)

Company Information	
Company Name:	Do you currently offer group medical benefits? If yes, fill out the below information.
Contact Person:	
Email:	Current Insurance Carrier:
Phone Number:	How many years have you been with your current carrier?:
Address:	Renewal Date:
City, State, Zip:	Current Broker:
Nature of Business or SIC/NAICS code:	Contribution to employee / dependent premium:
Are you a member of a trade association?: <input type="checkbox"/> Yes <input type="checkbox"/> No	NOTE: Reminder to attach your most recent billing statement, benefit summaries, and rates.
If yes, please specify which:	

How did you hear about us?

Sales Call Pro Benefits of Washington Website Referral Advertisement

Other (Please Clarify) _____

Additional Information - Medical Care Transition:

We strive to provide a smooth transition for all prospective enrollees so that there is no disruption to their current care.

Are there any enrollees being treated by specialty providers and/or facilities who might require coordination of care or on specialty medications requiring a prior authorization? *If yes, please specify providers or medications to the best of your ability:*

By completing this form, I certify the below information is correct to the best of my knowledge. This is not an application for coverage. Any group insurance coverage will not be effective until a proposal is provided, applications are completed by the group, and its employees and coverage are approved by the carrier.

I authorize the Consultants (Pro Benefits of Washington) to provide our company with a proposal for health insurance.

Authorized Representative Name: _____ Title: _____

Authorized Representative Signature: _____ Date: _____

