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?				
Contact Person:	If yes, fill out the below information.				
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?: 🔲 Yes 🛛 No	NOTE: Reminder to attach your most recent billing statement, benefit summaries, and rates.				
If <i>yes,</i> please specify which:					

How did you hear about us?

Sales Call	Pro Benefits of Washington Website	Referral	Advertisement
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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.

Authorized Representative Nume.	, muc.	
Authorized Representative Signature:	 Date:	

Census (Please complete below or send list in your preferred format):

Please list all W2 Employees & Owners (*Exclude 1099, temp, and seasonal hires, as well as those employees working <20 hours/wk*). If your entries exceed the lines below, feel free to duplicate this page to include all members.

Employee & Dependent Information (Required)							Required for Disability Quotes Only	
Full Name (Only Include dependents that want benefit coverage)	DOB (MM/DD/YYYY)	Sex (M/F)	Zip Code	Enrolled in Medicare? (Y/N)	Enrollment Status (Enrolling, Waiving, COBRA, Ineligible)	Relationship Type (Employee, Spouse, Domestic Partner, Child)	Salary \$ (Annual)	Job Title
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