BRAD SHIVERS INSURANCE AGENCY

Employer Health Insurance Quote Request

Information About Your Company

Full Legal Name of the Business						
Actual Physical Street Address						
Physical Address City		State	OR	Zip Code		
Mailing Address If it is Different						
Mailing Address City		State	OR	Zip Code		

Contact Information

Name	
Phone	
FAX	
E-Mail	
Other	

Information Needed by Insurance Companies and Health Plans for Quotes

Primary Business Activity of the firm		County where Corporate Headquarters is located	
Current Insurance Company or None		Planned Effective Date of the proposed insurance	

Your Company Policy

The required probationary or waiting period after an employee starts working full-time. Can be 0 to 90 days.	
Percentage of the premium for the employee-only portion you are planning to contribute. Must be 50% minimum.	
Percentage of the premium for the dependent portion you are planning to contribute, if any. May be 0% to 100%.	

Important Numbers

Total number of full and part-time employees working for the company. For federal HIPAA & COBRA applicability.	
Total number of employees working over 17.5 hours per week on a regular basis. For Oregon SEHI applicability.	
Total number of employees meeting your full-time work requirements whether coming on the plan or not.	
Total number of employees who are planning to enroll for insurance on the planned effective date of the plan.	

Types of Coverage You Plan to Offer

☐ Health Insurance	☐ Prescription Drug Coverage	☐ Dental Insurance	☐ Life Insurance	☐ Short-Term Disability	☐ Long-Term Disability	☐ Other Specify

Any Special Instructions?	

Existing Benefits If You Currently Have Group Insurance

Physician Copayment		Deductible or Hosp-Admin.		Coinsurance Percentage		Stop-Loss or Out of pocket	

Any Other Features Important to You?	

Signature and Instructions

Authorized Signature		Title or Position		Date	

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Employee Census

Name of Business		Date	

Employee Personal Information				Employee Status				Enrollment Status			
Employee Name	Sex	Age	Date Of Birth	Employee	Employee and Spouse	Employee and Family	Employee and Children (Child)	Eligible and Enrolling	Waiving for Other Group Coverage	Still in Waiting Period	Not Eligible or Part-Time

Signature and Instructions

Authorized Signature		Title or Position		Date	
FAX Quote Request Form and Employee Census to:				407-898-6103	