REQUEST FOR QUOTE FOR EMPLOYERS OF 2 TO 50 EMPLOYEES

Employer address (Street, City, State/Province, Zip/Postal Code)

EMPLOYER INFORMATION

Employer (correct legal name

Telephone Number

Authorized company representative (name and title)

Address (Street, City, State/Province, Zip/Postal Code)

SMALL EMPLOYER REFORM ACCEPTABLE GROUP ASSESSMENT

1. Does your company file taxes in this state? Yes ☐ No ☐ If no, please explain

2. Did you employ an average of 2-50 persons (including owners and partners), who worked at least 20 hours per week during the preceding calendar year? Yes ☐ No ☐

3. Are at least 75% of all eligible employees, after waivers for other group coverage, Medicare (Parts A&B), MCHA, Medical Assistance or General Assistance Medical Care applying for health coverage? Yes ☐ No ☐

4. Is there an employer- employee relationship? Yes ☐ No ☐

5. Will the employer contribute 50% or more of the employee cost of health coverage? Yes ☐ No ☐

COVERAGE INFORMATION

Medical ☐ Short Term Disability ☐ Long Term Care ☐ Life Insurance ☐ Cafeteria Plan ☐

Dental ☐ Long Term Disability ☐ Vision ☐ 401K ☐ Other

CENSUS INFORMATION

Eligible employees (including owners, partners, and officers) are those who work 20 or more hours per week at or from the business premises. Supply information about spouse's age and number of dependents only if you wish to obtain health coverage for them. (Rates for health insurance will NOT take into account the gender of the applicant. This information is however, required to rate life insurance.)

Emp Sex	Coverage	Date of Birth	# Children	Smoker	Salary	Date Of Hire