GROUP/COMMERCIAL QUOTE REQUEST FORM

HEALTH BENEFITS ASSOCIATES

3716 Lakeside Drive #100
Reno, NV 89509
Phone: (775) 828-1216
Fax: (775) 828-1277
Website: www.healthbenefits.net

Thank you for taking the time to complete this form

Once completed, please fax to **775-828-1277 or email a staff member in our office.**

This information is confidential and will not be shared with third party organizations outside of Health Benefits Associates, Inc.

Basic Employer Information:

Firm Name: _____ Your Name: _____

Address: _____ Phone Number: _____

City: _____ Fax Number: _____

State, Zip: _____ Nature of your Business: _____

County: _____ Policy Effective Date: _____

E-mail: _____

Current Insurance Co. (Optional) _____

Is the **Quarterly Wage and Contribution Report** available? (Usually available through your payroll company or software) ○ Yes ○ No

Optional Plan Information For Your Quote (Not Required):

Plan Type:	Deductible:	Doctor Office Copay	Quote Coverage For:
☐ HMO - Health Maintenance Organization	☐ $500	☐ $10	☐ Group Medical
☐ PPO - Preferred Provider Organization	☐ $1,000	☐ $20	☐ Group Dental
☐ POS - Point of Service Plan	☐ $2,000	☐ $50	☐ Group Vision
☐ Least Expensive Plan	☐ $3,000	☐ $75	☐ Group Life
	☐ $6,000	☐ N / A	☐ Group Disability

Please only list eligible employees who will be covered by the insurance plan.

Census Data:

#	Employee Name	Date of Birth	Spouse DOB	Child #1 DOB	Child #2 DOB	Child #3 DOB	Annual income. (life insurance only)	Home Zip Code
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