



Quote Request Form

Broker/Agent Information

Broker/Agent Name: _____
 Agency Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone #: _____ Fax #: _____

Employer/Group Information

Name of Business: _____
 Business Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone #: _____ Fax #: _____
 Nature of Business: _____ SIC Code: _____

If more than one location/division, please complete census for home office and each working location

Does Group have current coverage? YES NO
 If Yes, Current Carrier: _____ How Long? _____
 Current Plan Design: HMO POS PPO Other: _____
 Comments: _____

❖ ***Attach census information including EE birth dates, gender, number of dependents/marital status***

Proposal Plan Options

Select the appropriate box:

MEDICAL High Option Low Option Chamber/Association Plan

DENTAL RIDER YES NO

HOSPITAL SUPPLEMENT RIDER YES NO

Requested Effective Date: _____
 Total # of Active Full-Time Employees: _____ Part-time: _____

Is the quote **excluding** any of the following:

Management Non-Management Salary Hourly Union Non Union Other _____

Comments: _____

NOTE: Additional information/documentation will be required to establish eligibility and participation requirements.

Group should not cancel their present group coverage without receiving approval from Care Access Health plan. It is the Group's responsibility to ensure there is no lapse in coverage.

Please return completed form to: rate@mycareaccess.com or Fax to 305-614-5011