QualChoice® HEALTH INSURANCE

Request for Quote

Small Group (2-50 Eligible Employees Only)

Please be as accurate as possible when completing the form. Missing or incorrect information may cause the proposed rates to be invalid. Participation requirements at renewal: At least 75% of all eligible employees (excluding valid waivers) and 25% of all full time employees must enroll. Only full time employees are eligible.

Section I: Group Information

Group Name		Contact Name		
Contact Email		Contact Phone Number	Federal Tax ID	
Employer Physical Address		City	State	Zip Code
Type of Business	Years in Business	SIC Code	Requested effective date for coverage	No. of FTEs

Amount of employer contribution. Employer required to contribute a minimum of 50% towards the employee premium.

Employee _____% Dependent _____%

Do you currently have group coverage?

☐ **Yes** ***If yes***, complete Section II ☐ **No** ***If no***, skip to Section III

Section II: Current Benefit Information *Complete only if you* **currently** *have group coverage*

Name of Current Carrier			How long has employer been with this carrier?		
Current benefits	Deductible $ _____	Co-payment $ _____	Coinsurance $ _____	Out of Pocket $ _____	Rx $ _____
Current Rates (*total monthly premium*)			Renewal Rates (*total monthly premium*)		

Section III: Employee Census Data – Sample *Complete Attachment 1 on the next page following the sample below.*

Coverage Desired: EO=*employee only* **ES**=*employee+spouse* **EC**=*employee+child(dren) (indicate # of children)* **EF**=*employee+family* **W**=*waiving coverage*

See sample below: Employee #1 coverage is "**EF**" = employee+family. The next 4 rows list Employee #1 information: self, spouse, and two children. Employee #2 coverage is "**ES**" = employee+spouse. The next 2 rows list Employee #2 information: self and spouse.

Employee	Gender (M/F)	Date or Birth (mm/dd/yyyy)	Coverage Desired					Home ZIP Code
			EO	ES	EC	EF	W	
Employee 1-Self	M	12/12/1965				X		72223
Employee 1-Spouse	F	02/02/1965				X		72223
Employee 1-Child	M	01/01/1990				X		72223
Employee 1-Child	F	02/02/1992				X		72223
Employee 2-Self	F	11/11/1985		X				72211
Employee 2-Spouse	M	10/10/1987		X				72211

Section IV: Instructions

Fax or email completed form + Employee Census Data to:

QualChoice
Email: **qca_salesintake@qualchoice.com**
Fax: **833.744.1739**

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Attachment 1: Employee Census Data Form

Following the **Sample** in Section III on page 1, list each full-time eligible employee's information (employee names not required at this time). Copy this page as needed or submit all required information in a Word or Excel document. You must use the exact column fields as you see below to receive a quote. Group must have 2-50 eligible employees.

Coverage desired: **EO**=*employee only* **ES**=*employee+spouse* **EC**=*employee+child(dren) (indicate # of children)* **EF**=*employee+family* **W**=*waiving coverage*

Group name

Employee	Gender	Date of Birth *(MM/DD/YYYY)*	Coverage Desired					Home ZIP Code
			EO	ES	EC	EF	W	

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