

# BIAW Health Insurance Program Quote Request

If you have 5 or more employees and would like to see savings on group insurance, complete this form and fax to:

**Sales Consultants**  
**Capital Benefit Services, Inc.**  
 15375 SE 30th Place, Suite 380, Bellevue, WA 98007

FAX: (425) 643-6728  
 PHONE: (800) 545-7011 ext. 6  
 EMAIL: [sales@epkbenefits.com](mailto:sales@epkbenefits.com)

**In order to obtain a quote, our carriers (Regence BlueShield & Group Health) require all sections of this form to be completed.**

Group Information

|   |   |
|---|---|
| Company Name:   | Phone:  |
| Contact Person:   | Fax:  |
| Address:  | Email:  |
| City, State, Zip:   | Type of Business:   |
| Are you a member of your Local Building Association ? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> |   |
| If yes, please provide: Which Association?  | Membership ID# <span style="float: right;">Member Since:</span> |

I authorize the BIAW Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the BIAW Trust.

Authorized Representative:
Date:

Current Health Insurance

Group Medical
 Group Dental
 Individual Policies
 None

CURRENT INSURER: \_\_\_\_\_ RENEWAL MONTH: \_\_\_\_\_

*Please attach a summary of benefits of your current medical (and dental if applicable) plan or provide the following:*

Benefit Level (80/20): \_\_\_\_\_ Copay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Rx Benefit: \_\_\_\_\_

|                     | CURRENT RATES      |        | RENEWAL RATES      |        |
|---------------------|--------------------|--------|--------------------|--------|
|                     | Medical / Rx Drugs | Dental | Medical / Rx Drugs | Dental |
| <i>Employee</i>     |                    |        |                    |        |
| <i>Spouse</i>       |                    |        |                    |        |
| <i>Single Child</i> |                    |        |                    |        |
| <i>Children</i>     |                    |        |                    |        |

What percentage do you pay toward the cost for Employees? \_\_\_\_\_% Dependents? \_\_\_\_\_%  
*(The company must pay a minimum of 75% for employees, there is no requirement for dependent(s) contribution).*

Employee Census

**Please include all Eligible Employees; Eligible Employees include all full-time, active employees and owners who have satisfied your company's probationary period for insurance coverage. Please include additional census if your company has 21 or more employees.**

| SEX<br>M/F | BIRTHDATE or AGE<br>as of 4/1/04 | SP | DEPENDENTS |      | SEX<br>M/F | BIRTHDATE or AGE<br>as of 4/1/04 | SP | DEPENDENTS |      |
|------------|----------------------------------|----|------------|------|------------|----------------------------------|----|------------|------|
|            |                                  |    | 1CH        | 2+CH |            |                                  |    | 1CH        | 2+CH |
|            |                                  |    |            |      |            |                                  |    |            |      |
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|            |                                  |    |            |      |            |                                  |    |            |      |