ADVANTAGE
HEALTH PLANS TRUST

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Fields marked with an asterisk "*" are required.

This quote request template must be filled out completely. Please be sure to indicate "None" if applicable. Advantage Health Plans Trust will not accept the questionnaire if incomplete. Use additional paper if necessary.

*Date _____ *Proposed Effective Date: _____

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
*Company Name					
*Street Address					
*City		*State		*Zip	
County		Benefits Contact & Phone #			
*Total Number of employees on payroll:		*Total Full Time:		*Total Number of employees currently enrolled in health care plan:	
		*Total Part Time:			
*Are any health plan enrollees NOT paid employees (other than spouses or children)? ☐Yes ☐No ***If yes, please provide names and details:					
*Current Health Carrier:		*Health Carrier Renewal Date:			
*Is your current Plan Self-Funded? ☐Yes ☐No Don't Know ***If yes, please provide claims.					
*Are you currently with a PEO? ☐Yes ☐No *If yes, name of PEO:		*Any ineligible class of employees ☐Yes ☐No If yes, which class:			
Please provide a complete description of your business operation:				SIC Code:	
*Number of Locations:		*Please identify all states of operation:			
*Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company, or a PEO? ☐Yes ☐No *If yes, please briefly explain the reason why and when this occurred:					

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II. RATE HISTORY (if more than 3 plans, include the 3 most popularly-elected plans)				
Plan 1 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff. _____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 2 Name:	**# Enrolled: _____**	**Renewal Rates (eff. / /)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 3 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff. / /)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION (Individual, in-network only)			
Current Plan Names:	**1:**	**2:**	**3:**
Current Plan Types:	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Annual Deductible			
Co-Insurance (as %)			
Out-of-Pocket Max (excluding deductible)			
Office Visit Copay			
Prescription Drug Copay generic / brand formulary / brand non-formulary	/ /	/ /	/ /

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (by $ or %)				

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Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

GENERAL ILLNESS QUESTIONS:	*To the Best of My Knowledge (any or all):
a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability? c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? ***(If yes to any or all, please provide details in the table below.)***	☐ **Yes** ☐ **No**

SPECIFIC ILLNESS QUESTION:

*Is anyone currently being treated or been advised to seek treatment for any of the following?

***Please check all that apply:**

- ☐ AIDS or testing HIV Positive
- ☐ arthritis
- ☐ back disorder
- ☐ cancer
- ☐ diabetes
- ☐ heart disease
- ☐ kidney disorder
- ☐ liver disease
- ☐ mental illness
- ☐ muscular disorder
- ☐ nervous system disorders
- ☐ respiratory disease
- ☐ stroke
- ☐ substance dependency
- ☐ transplants
- ☐ tumor
- ☐ other serious conditions

(If any boxes are checked, please provide details in the table below.)

Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

Known Medical Conditions to the best of your knowledge (continued):

*IS ANYONE CURRENTLY PREGNANT? If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy. *This includes employees, dependents or COBRA participants.*	*To the Best of My Knowledge: ☐ Yes ☐ No

Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

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I certify that the statements herein are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify the entity collecting this information of any changes that occur after signing this Quote Request Template and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement may be terminated for breach. In such cases, my company may be liable for damages.

This information is gathered for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

***Authorized Signature**	***Title**	***Date**
***Print Name**	***Print Name of Company**	
Broker / Sales Signature	**Broker / Sales Print Name**	**Date**