

BIAW Health Insurance Program Quote Request

If you have 2 or more employees and would like to see savings on group insurance, complete this form and fax to:

Scott Keno
Benefit Services Northwest
Spokane, WA 99224

FAX: (509) 448-4451
PHONE: (509) 863-6500
EMAIL: skeno@epkbenefits.com

In order to obtain a quote, the BIAW Trust carriers 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide: Which Association? _____	Membership ID# _____ Member Since: _____
I authorize the BIAW Trust Consultant (Benefit Services Northwest) 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 _____ TRUST / PROGRAM _____ RENEWAL DATE _____
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
Employee				
Spouse				
Single Child				
Children				

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 M/F	DATE of BIRTH	SP	DEPENDENTS		SEX M/F	DATE of BIRTH	SP	DEPENDENTS	
			1CH	2+CH				1CH	2+CH

PLEASE SEND MY CUSTOM QUOTE VIA EMAIL

(If you are requesting an email response for a quote, please verify your email address at the top of the page)

BIAW / MBA Risk Appraisal Form

Please answer each question to the best of your knowledge for all persons to be insured under your plan including employees, spouses, and dependent children.

If the answer to any question is "yes," please use the additional space to provide specific information (however, do **NOT** include names or social security numbers).

1. Are you aware of any employees or dependents that have been treated, hospitalized or had surgery for a serious illness. These include, but are not limited to, cancer, AIDS, diabetes, cardiovascular disease, organ transplant, mental disorders, alcoholism, drug abuse, obesity, etc?

Yes No

2. Are you aware of any employees or dependents that have a hospitalization or surgery pending or have been advised that hospitalization or surgery is necessary?

Yes No

3. Are you aware of any employees or dependents that are currently disabled or not actively at work because of illness or injury?

Yes No

4. Are there any employees or dependents on COBRA continuation coverage?

Yes No

If employees are on COBRA, please describe any major medical situations.

5. Are there any handicapped children who have passed the limiting age and are currently insured?

Yes No

6. Are you aware of any claims that have exceeded \$25,000 in the last 12 months on any insured employee or dependent?

Yes No

If so please provide an estimate of the amount paid, an explanation of the medical condition and the likelihood of future claim expenses (do **NOT** include names or social security numbers).

7. Are you aware of any employees or covered dependents with an existing pregnancy?

Yes No

If "Yes," are multiple births expected?

Yes No

By completing this form I certify that the above information is correct to the best of my knowledge. This is not an application for coverage. Any group insurance coverage will not be made effective until a proposal is made to the group, an application is completed by the group, and coverage is approved by the MBA Trust Carriers.

Name of Individual Completing Form

Title

Signature

Name of Company

Date

RA 9/12/05

Upon completion please fax this form to (425) 643-6728