

PA-Employer Information Sheet

Please complete all requested information. Failure to complete all fields will result in delayed processing of your quote.

Business Name: _____ Billing Address: (if different) _____
 Street Address: _____
 (PO Boxes not accepted) _____
 State/Zip _____
 County: _____ Association: _____
 Phone: (____) _____ Fax: (____) _____
 Date Established: _____ Years In Business: _____ Tax ID # _____ UC-2? Y / N

of Subsidiaries: _____ Type of Business:
 Subsidiary Location(s): _____
 Proprietorship Corporation Partnership
 LLC Municipality Limited Partnership
 Non-profit Union Group Other: _____

Nature of Business: _____ SIC code: _____

Total Employed (Part Time-Full Time-Waivers)	Total Eligible for Medical	# of Qualified Beneficiaries under COBRA	# Employees Out-of- Area

Contact/Decision Maker: _____ Title: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Proposed Effective Date: _____ Provide Out of Area Coverage if Applicable? Y / N

Has Company been insured by HealthAssurance in the last 12 months? Y / N If Yes, prior group# _____

Employer Contributions: _____ % of single premium toward the cost of each tier --OR--
 _____ % of premium rates for each coverage tier

Employee is eligible: 1st of the following month 1st of month following _____ days
 Upon Hire Other _____

Current Carrier: _____ Proposed Termination Date: _____

Worker's Comp Carrier: _____

Current / Renewal Rates	Employee	Employee / Spouse	Employee / Child	Family	Group Premium

Is there an HRA plan currently in effect? Yes No If yes to HRA, what is the dollar amount? _____

Is there a Section 125 plan currently in effect? Yes No

Plan Requested:

HMO PPO POS

Riders:

RX _____
 Vision
 Dental _____

OOA _____

Dual Option: Yes No If Yes, plan: _____ (For Dual Option must have 20+ enrolling, only one RX option)
 Contact your Marketing Representative for current product pairings

Marketing Rep: _____ Broker: _____

The above information is required by Underwriting prior to generating a premium quote. Please attach a census page with the gender, coverage status, date of birth, residence zip codes for an illustrative quote. Please enclose medical forms if requesting final rates. Fax to your Marketing Representative.

PA-Employer Information Sheet

IN AREA CENSUS INFORMATION

NAME <i>(Optional)</i>	DATE OF BIRTH	GENDER	ZIP CODE *	COVERAGE TIER <i>(e.g., single, family etc)</i>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				

Tier 1 = Single; Tier 2 = EE + 1 Child; Tier 3 = EE + 2 Children; Tier 4 = EE + Spouse; Tier 5 = Family

* Enter the zip code where the employee resides