BIAW Health Insurance Program Quote Request

If you are a member of the BIAW and would like to receive information on the available Health Insurance Plans, complete these forms and fax to:

Sales Consultants FAX: **(425) 643-6728**

Capital Benefit Services, Inc. PHONE: **(800) 545-7011 ext. 6**

15375 SE 30th Place, Suite 380, Bellevue, WA 98007 EMAIL: sales@epkbenefits.com

In order to obtain a quote, our carriers require all sections of this form to be completed.

Group Information

Company Name:	Phone:
Contact Person:	Fax:
Address:	Email:
City, State, Zip:	Date Business Started:
Nature of Business:	SIC Code:

Are you a member of your Local Building Association ? ☐ Yes ☐ No

If yes, please provide: Which Association ? Membership ID#: Member Since:

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