BeHealthy Alliance of Johns Creek[sm] (SAMPLE)
Group Insurance Quote Request Form

Date Form Completed: _____ Desired Effective Date: _____

Contact Person/Title: _____ Contact Telephone: ( )_____

How do you want us to transmit the finished proposal to you? Check one: □ By E-mail □ By Fax

E-mail Address: _____ Fax Number: ( )_____

Group Information:

Company Name: _____

Street Address: _____
Street City County Zip

Chamber of Commerce Member: □ Yes □ No If yes, which chamber? _Johns Creek_Chamber of Commerce

Specific Type of Business: _____

Length of Time in Business: _____ years _____months SIC Code (if known): _____

Insurance Coverage Information:

☐ Group Health
☐ Individual Health
☐ Group Dental
☐ Voluntary Dental
☐ Group Life/AD&D
☐ Disability Overhead Expense
☐ Long Term Care
☐ Group Short Term Disability
☐ Voluntary Short Term Disability
☐ Group Long Term Disability
☐ Voluntary Long Term Disability

Number of Full-Time Employees: _____ Total Number To Be Covered By Group Health Insurance: _____

Current GROUP Health Carrier: _____ (excluding *individual* policy coverage)

Current Insurance Agent: _____ Agent's Phone: ( )_____

Census Data Information: (Circle gender, list ages, dependent status & number of children covered)

	Sex	Age	Dependent Status	# of Children		Sex	Age	Dependent Status	# of Children
1.	M F	____	____	_____	13.	M F	____	____	_____
2.	M F	____	____	_____	14.	M F	____	____	_____
3.	M F	____	____	_____	15.	M F	____	____	_____
4.	M F	____	____	_____	16.	M F	____	____	_____
5.	M F	____	____	_____	17.	M F	____	____	_____
6.	M F	____	____	_____	18.	M F	____	____	_____
7.	M F	____	____	_____	19.	M F	____	____	_____
8.	M F	____	____	_____	20.	M F	____	____	_____
9.	M F	____	____	_____	21.	M F	____	____	_____
10.	M F	____	____	_____	22.	M F	____	____	_____
11.	M F	____	____	_____	23.	M F	____	____	_____
12.	M F	____	____	_____	24.	M F	____	____	_____

Dependent Status Abbreviations

EE = Employee Only
ES = Employee + Spouse
EC = Employee + Child(ren)
EF = Employee + Family
LO = Life Only (NO medical coverage desired)

All Known Medical Conditions (w/ dates, treatment, meds, status)

_____
_____
_____
_____
_____

Special Situations: --Any out of state employees? (If so, identify them above with *zip code* added.)
--Management-Only Coverage? ☐ Yes ☐ No
--If only 2 employees, is this is a husband & wife-only group? ☐ Yes ☐ No

When completed, FAX to Purchasing Alliance Solutions, Inc., at 770-565-1822 or 866-782-8254.