

101+ CENSUS & REQUEST FOR QUOTE

Submit Completed Census to your dedicated Account Executive or submit by email to sales@dickerson-group.com



1918 Riverside Dr. • Los Angeles, CA, 90039
800-457-6116 • 323-662-7200 • License #0M29112

Broker Information ✓

Date: _____
 Broker Firm Name: _____
 Producer Name: _____
 Broker Address: _____
 City: _____
 State: _____ ZIP Code: _____
 Phone: _____ Fax: _____
 Email: _____

Broker of Record? Yes No

Group Information ✓

Company/Group Name: _____
 Address: _____
 City: _____
 State: _____ ZIP Code: _____
 DBA: _____ Phone: _____
 Nature of Business: _____
 SIC Code: _____ Years in Business: _____
 Effective Date: _____ Waiting Period: _____
 # (non-COBRA) Eligible Employees: _____
 # COBRA Employees: _____
 Common ownership with other companies? Yes No

Medical Information ✓

5-Year Carrier History

	Carrier Name	Type of Coverage	Period Insured or # of Years
1			
2			
3			
4			
5			

If Kaiser is Present: Kaiser Will Remain Total Replacement

Employer Contribution Amount: HMO

per Employee: _____

per Dependent: _____

Employer Contribution Amount: PPO

per Employee: _____

per Dependent: _____

Current Rates ✓

If age banded, please attach billing statement

	HMO	PPO	Kaiser
EE			
EE/SP			
EE/CH			
FAM			

Renewal Rates ✓

Please attach complete renewal, including large claims report

	HMO	PPO	Kaiser
EE			
EE/SP			
EE/CH			
FAM			

Current Benefits Description ✓

Please attach benefit summary(ies)

Carriers to be Quoted



Kaiser
101-300

Anthem Blue Cross
Call for details

Cigna
25-250

Health Net
101-500

Aetna
Call for details

Blue Shield
Call for details

Plans to be Quoted



Medical:

HMO

PPO

HSA

POS

Life:

Amount: _____ Basis: _____

Dental:

Current Carrier: _____

Current Benefits: _____

Current Rates: _____

Requested Benefits: _____

Vision:

Current Carrier: _____

Current Benefits: *Please attach benefit summary(ies)*

Current Rates: _____

Requested Benefits: _____

STD/LTD:

Current Carrier: _____

Current Benefits: *Please attach benefit summary(ies)*

Current Rates: _____

Health Questions



Yes/No

- Has any insured received medical benefits in excess of \$15,000 in the last 12 months?
If **YES**, please provide details: _____
- Are there any disabled participants?
If **YES**, please provide #: _____
- Are there any catastrophic or other serious medical conditions, pregnancies, or coverage of members not actively at work, or currently hospital-confined?
If **YES**, please provide details: _____
For pregnancies, please provide #: _____
- Are all employees covered by workers' compensation insurance?
if **NO**, please provide # not covered: _____
- Has any owner or principal filed bankruptcy within the past seven years, or known to be planning to file bankruptcy? _____
- Does the employer reimburse employees for any part of their normal out-of-pocket costs? (copays, deductibles, coinsurance, etc.) _____

Note: The group may not self-insure any part of the employees' normal out-of-pocket costs or provide any type of "GAP Insurance."

7. Reason for shopping: (mark all that apply) Market Check Unhappy with Rates Unhappy with Benefits
Other: _____
