Health Insurance Quote Request Form

NMTA Health Trust

Send your completed forms to: CC-CH

Capital Benefit Services, Inc.

sales@capitalbenefitservices.com / www.capitalbenefitservices.com / Phone: (425) 641-8093

If you currently offer group coverage please provide the following information:

▪ Most recent billing statement ▪ Current benefit summaries ▪ Renewal information / rates

Thank you for your interest in our program!

Please complete the below information to the best of your ability.

Your group does not need to be a current member of a sponsoring organization to receive a proposal, but will need to be in order to enroll.

By completing this form, I certify the below information is correct to the best of my knowledge. This is not an application for coverage. Any group insurance coverage will not be effective until a proposal is provided, applications are completed by the group, and its employees and coverage are approved by the carrier.

I authorize the Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the Trust.

Authorized Representative Name: _____ Title: _____

Authorized Representative Signature: _____ Date: _____

Company Information

Company Name:	Email:
Phone Number:	**Do you currently offer group medical benefits?** If *yes* , fill out the below information.
Contact Person:	
Address:	Current Insurance Carrier:
City, State, Zip:	Trust / Program:
Nature of Business:	Renewal Date:
Are you a member of a trade association?: ◯ Yes ◯ No	How long have you been with your current program?:
If *yes* , please specify which:	Current Broker:

How did you hear about the NMTA Health Trust?

◯ Sales Call ◯ Health Trust Website ◯ Referral ◯ Membership Event ◯ Advertisement ◯ Other (Please Clarify) _____

Additional Information - Medical Care Transition:

We strive to provide a smooth transition for all prospective enrollees so that there is no disruption to their current care. Please review the following questions and answer to the best of your abilities:

Are there any prospective enrollees being treated by specialty providers and/or facilities who might require coordination of care?
If yes, please specify providers and/or facilities:

_____

_____

Are you aware of any specialty medications utilized by prospective employees that would require a prior authorization?
If yes, please specify medications:

_____

_____

Please complete Census information on the following page.

Census:

Please list all W2 Employees & Owners *(Exclude 1099, temp, and seasonal hires, as well as those employees working <20 hours/wk)* .

Employee Information					For groups with existing group-sponsored medical coverage, please complete the following:		
					Employee Enrollment	**Dependent Information**	
Employee Name *(Optional)*	DOB	Sex **M / F**	Zip Code	Enrolled in Medicare? **Y / N**	Enrollment Options Choose: **E**nrolled, **W**aived, or **C**obra	Spouse / Domestic Partner on plan? **Y / N**	Number of Children on plan? (Up to age 26)
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