

GROUP HEALTH INSURANCE QUOTE REQUEST FORM

COMPLETE AND SUBMIT TO **Q & A INSURANCE MARKETING**
THE EXCLUSIVE BROKER FOR YOUR EXCHANGE/ASSOCIATION HEALTH PROGRAM
Lic. # 0B17048
FAX: 916-933-6055 OR EMAIL: Denise@QAIM.COM

Employer Information

Employer Name: _____ Contact Name: _____
Address: _____ Phone: _____
City, State, Zip: _____ FAX: _____
Email: _____

Are you a current member of a Builders' Exchange/Association? Yes No If yes, which one? _____

Current Plan Information

Insurance Company: _____ Office Visit Co-Payment: _____

Plan type: HMO PPO HSA Other _____

Other plans currently offered: _____

I am interested in (Check all that apply):

Medical-HMO Medical-PPO Medical-HSA Dental Vision Chiro/Acup Life

Employee Name	Sex	DOB	Spouse Covered	# covered children	Zip Code
1.	M/F		Y/N		
2.	M/F		Y/N		
3.	M/F		Y/N		
4.	M/F		Y/N		
5.	M/F		Y/N		
6.	M/F		Y/N		
7.	M/F		Y/N		
8.	M/F		Y/N		
9.	M/F		Y/N		
10.	M/F		Y/N		
11.	M/F		Y/N		
12.	M/F		Y/N		
13.	M/F		Y/N		
14.	M/F		Y/N		
15.	M/F		Y/N		