

Group Health Information

In order for Health Care Solutions, LLC to quote group health plans, we need some information from you. Please complete the following and fax the information to 618-997-8161 or email to stephanie@hcsolutionsonline.com

Group Name:

Address:

Contact Name:

Contact Phone Number:

Employer Pays _____% of employee premium.

Employer Pays _____% of the dependent premium.

Please provide the current renewal date.

Where is the corporate headquarters located (city & state)?

How many full time (32 hours or more weekly) employees does your company employ?

How many employees are on your group health plan?

Are all employees and dependents located in the same state? If not please provide the states where they reside or the situation?

Who is your current insurance carrier?

Please provide a benefit summary/outline of your current group health plan.

Please provide a current bill or the following information in order for Health Care Solutions to determine if quotes are lower than current premium.

Employee:

Employee + Child:

Employee + Spouse:

Family:

Total Monthly Premium:

Other Comments or information:

Employee Census

Type of Coverage*	
EE = Employee Only	F = Family
EC = Employee Child	LO = Life Only
ES = Employee Spouse	W = Waived/Other Coverage

Name	Gender	Date of Birth	Type of Coverage*	No. of Children	Spouse Date of Birth	Home Zip Code
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