

California Small Group Quote Request

Telephone: (800) 801-2300
Fax: (800) 609-0111
<http://www.warnerpacific.com>

Broker Name _____
Group Name _____

Broker/Agency Information

Broker Name _____ Agency _____
Address _____
City/State/Zip _____ Phone _____
Broker License # _____ Fax _____
Email _____
Warner Pacific
Sales Executive _____

Group Information

Group Name _____
Requested Effective Date _____ Nature of Business _____ SIC Code _____
Employer ZIP _____ Current Carrier _____ Current RAF _____
Carve-Out _____ Requested RAF _____ Renewal RAF _____
Employer contribution for employee & dependents EE: _____ Dep: _____

Quote Specifications

Date Needed ___/___/___
Bind Quote Yes No
Send Via Email Overnight Mail Fax Pickup
Default Dep. Status _____ Medical Dep. Status _____ Dental Dep. Status _____ Vision Dep. Status _____
Please check all products to be included in your quote. Include all products listed Include AD&D/LTD/STD

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Carrier	<input type="checkbox"/> All Medical	<input type="checkbox"/> All Dental	<input type="checkbox"/> All Ancillary
Aetna	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA <input type="checkbox"/> Indemnity	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Life
Anthem Blue Cross	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Vision <input type="checkbox"/> Life
Blue Shield	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA <input type="checkbox"/> POS		
CaliforniaChoice	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO	
Delta Dental (min. 5 lives)		<input type="checkbox"/> PPO <input type="checkbox"/> HMO	
Health Net	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA <input type="checkbox"/> POS <input type="checkbox"/> EPO	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Vision <input type="checkbox"/> Life
HSA California	<input type="checkbox"/> HSA <input type="checkbox"/> Indemnity	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO	
Humana		<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Vision <input type="checkbox"/> Life
Kaiser Permanente	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA <input type="checkbox"/> POS	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity	
Kaiser Permanente Choice Solution	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA <input type="checkbox"/> POS	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> FFS	
MetLife/Safeguard (min. 7 lives / min. 5 lives)		<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Vision
SeeChange Health	<input type="checkbox"/> PPO <input type="checkbox"/> HSA		
Sharp Health Plan	<input type="checkbox"/> HMO		
UnitedHealthcare	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> Vision <input type="checkbox"/> Life
VSP (min. 3 lives)			<input type="checkbox"/> Vision

For additional ancillary carrier options, please select from the list below. Please allow 3-5 business days for receipt of quotes from carriers who are listed in this section.

Carrier	<input type="checkbox"/> All Dental	<input type="checkbox"/> All Ancillary
American General Life Companies	<input type="checkbox"/> PPO	<input type="checkbox"/> Life
CaliforniaChoice		<input type="checkbox"/> Vision <input type="checkbox"/> Life
HSA California		<input type="checkbox"/> Vision <input type="checkbox"/> Life
Principal Financial Group (two lines – min. 3 lives/standalone – min. 5 lives)	<input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> Indemnity	<input type="checkbox"/> Vision <input type="checkbox"/> Life

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Group Name _____

Census Information

Employee Name	Gender	Age or DOB	Dependent Status			Home ZIP	COBRA	1099	Dependent Status Legend
			Med.	Dent.	Vis.				
1									
2									EE – Employee Only
3									ES – Employee & Spouse
4									1C – Employee & One Child
5									+C – Employee & Children
6									FA – Family
7									W – Waived
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Broker Name _____

Group Name _____

Census Information Continued

Employee Name	Gender	Age or DOB	Dependent Status			Home ZIP	COBRA	1099	Dependent Status Legend
			Med.	Dent.	Vis.				
26									
27								EE – Employee Only	
28								ES – Employee & Spouse	
29								1C – Employee & One Child	
30								+C – Employee & Children	
31								FA – Family	
32								W – Waived	
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