

Colorado Small Group Quote Request

Telephone: (800) 801-2300
Fax: (888) 215-8525
<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 _____

Carve-Out _____

Employer contribution for employee & dependents EE: _____ Dep: _____

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Quote Specifications

Date Needed ___/___/___

Bind Quote Yes No

Send Via Email Fax Pickup

Default Dep. Status _____ Medical Dep. Status _____ DentalDep. Status _____ Vision Dep. Status _____

Please check all products to be included in your quote. Include all products listed Include AD&D/LTD/STD

Carrier	<input type="checkbox"/> All Medical	<input type="checkbox"/> All Dental	<input type="checkbox"/> All Ancillary
Alpha Companion		<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity	
Anthem Blue Cross	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA	<input type="checkbox"/> PPO	<input type="checkbox"/> Vision <input type="checkbox"/> Life
Beta		<input type="checkbox"/> PPO <input type="checkbox"/> HMO	
CIGNA (min. 20 lives)		<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO	
Delta Dental		<input type="checkbox"/> PPO	
Humana	<input type="checkbox"/> PPO <input type="checkbox"/> HSA <input type="checkbox"/> POS	<input type="checkbox"/> PPO <input type="checkbox"/> Indemnity	<input type="checkbox"/> Vision <input type="checkbox"/> Life
Kaiser Permanente	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA		
Principal	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA		
Rocky Mountain Health Plans	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> HSA		
The Standard			<input type="checkbox"/> Vision <input type="checkbox"/> Life
UnitedHealthcare	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	<input type="checkbox"/> PPO <input type="checkbox"/> HMO	
VSP			<input type="checkbox"/> Vision

For additional ancillary carrier options, please see the Products & Commission Schedule in the Broker Toolbox on www.warnerpacific.com or consult with your Warner Pacific Sales Executive or Rating Analyst. Please allow 3-5 business days for receipt of quotes from carriers who do not appear on this request form.

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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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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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