Colorado Quote Request Form

Anthem Blue Cross and Blue Shield
Individual & Small Group Sales Support
700 Broadway – ISG0904
Denver, Colorado 80273

Fax: 303-863-1721
Toll Free Fax: 866-628-3096
E-mail: isgquotes@anthem.com

For Internal Use Only

RSM:_____
Rate Default:_____
UW:_____
Quoter:_____
E-mail date_____
Fax Date:

BROKER INFORMATION: **Bolded** information is required. Missing information may delay the quote.

Agency Name:	**Broker Name:**	**Broker No:**
Email Address:	**Fax:**	**Phone:**

EMPLOYER INFORMATION:

Group Name:			**Effective Date:**	**# Full Time Employees:**
Street Address (No PO box please):			**Contact Name:**	
City:	**State:**	**Zip Code:**	**Fax:**	**Phone:**
SIC Code:	**Type of business:**		**Current Carrier:**	

PLEASE CHOOSE PLAN DESIGNS TO QUOTE: **Check the applicable box(es) for specific products or "PrintAll".**

EmployeeElect Health Plan Coverage			
☐	**PPO $30 Copay** RX: $15/30/50/30%	☐	**Premier PPO $15 Copay** RX: $10/30/50/30%
☐	**PPO $40 Copay** RX: $20/40/50/30%	☐	**Premier PPO $25 Copay** RX: $15/30/50/30%
☐	**PPO $35 Copay GenRx** RX: $15 Generic Only	☐	**Premier HMO** RX: $10/30/50/30%
☐	**PPO $45 Copay GenRx** RX: $15 Generic Only	☐	**Classic HMO** RX: $15/40/60/30%
☐	**Premier HMOSelect** RX: $10/30/50/30%	☐	**Classic HMOSelect** RX: $15/40/60/30%
☐	**PPO 2000 (HSA compatible)**	☐	**PPO 3500 (HSA Compatible)**
Standard		**Basic**	
☐	**PPO Standard Plan**	☐	**PPO Basic Plan**
☐	**HMO Standard Plan**	☐	**HMO Basic Plan**

Life & Disability Coverage

Group Term Life & AD&D ☐ Yes ☐ No

☐ Salary Based Plans (Maximum of $200,000. Salary must be included in census.)
☐ 1 x Salary ☐ 2 x Salary

☐ Class Based Plans (No class can be greater than 2.5x the next lower class.)
Class 1:_____ (class description), Amount:_____ ($15,000 to $200,000)
Class 2:_____ (class description), Amount:_____ ($15,000 to $200,000)

☐ Flat Benefit Plan ($15,000 to $200,000) $_____ for all ee's.

☐ Optional Life: Employer's choice to offer / Employee's choice of amt: $25k/50k/75k/100k

Dependent Group Life (Employer's choice) ☐ Yes ☐ No
☐ Option #1: $10,000 Spouse; $10,000/child
☐ Option #2: $5,000 Spouse; $5,000/child

Short Term Disability ☐ Yes ☐ No
☐ % of Salary Benefit: 66.7% (Salary must be included in census)
☐ 1/8/13 weeks ☐ 1/8/26 weeks ☐ 15/15/26 weeks
☐ Flat Benefit: $200/week
☐ 1/8/13 weeks ☐ 1/8/26 weeks ☐ 15/15/26 weeks

Long Term Disability ☐ Yes ☐ No (Salary must be included in census)
☐ Gold: Age 65 RBD, 60% to $6000, 90 day elim
☐ Gold: Age 65 RBD, 60% to $6000, 180 day elim
☐ Silver: 5 year RBD, 60% to $6000, 900 day elim
☐ Silver: 5 year RBD, 60% to $6000, 180 day elim
☐ Bronze: 2 year RBD, 50% to $3000, 180 day elim

"PrintAll" Health Plans	**Vision coverage**	**Dental Coverage**
	☐ Yes ☐ No	☐ Yes ☐ No
☐ All products will be quoted PPO/HMO/HSA/Basic/Standard	**Association Discount** (check if applicable) ☐ Bar Assoc ☐ Chamber	

Please note that groups will be rated as follows: Groups size 9 or below = Age rates Group size 10-50 = Composite Rates

To ensure timely turn-around of your quote request, please check all applicable boxes, fill out genders and ages/DOB and coverage type requested for each employee.

Are you aware of any Medical Conditions of which you want UW to be aware? (please circle) YES NO

Emp # ____	
Emp # ____	
Emp # ____	
Emp # ____	

FORM NO. 98864 (REV 12-05)

Anthem

CENSUS: ** **Elected Coverage**: Employee Only = **E** Employee Spouse = **ES** Employee Child(ren) = **EC** Family = **F**

Census must include salary amounts if Life or STD is function of salary. Please include additional sheets if necessary.

	Employee Name	Gender	Date of Birth or Age	Elected Coverage**	# children	Zip Code (7Counties)	Waived/COBRA (if applicable)	Salary (if applicable)
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2								
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