

SELF INSURANCE QUOTE SURVEY**Western Benefits, Inc.**

It is our pleasure to provide you with a preliminary design and quote for your **Self Insurance Plan**. Please complete the information fields below to the greatest extent possible. This data is critical to the process of designing the most favorable and cost-effective plan for you. Complete information improves our ability to secure the **best possible rates** for your program.

YOUR NAME: _____

COMPANY NAME: _____

MAILING ADDRESS _____

PHYSICAL ADDRESS(S): _____

STREET or P.O. BOX

*Please attach list of multiple locations

STREET

CITY STATE ZIP

CITY STATE ZIP

PHONE: _____

FAX: _____

EMAIL: _____

OTHER CONTACT: _____

PHONE: _____

FAX: _____

EMAIL: _____

ARE YOU CURRENTLY SELF INSURED? Yes No If yes, CURRENT RETENTION: \$ _____

NAME OF CURRENT INSURER _____

PLAN EFFECTIVE DATE _____ / _____ / _____
MO DAY YEAR**CLAIM INFORMATION REQUIRED:**

IF YOU ARE CURRENTLY SELF INSURED, PLEASE PROVIDE:

 Detailed Claim Reports For The Last 2 -3 Years along with updated status of any claims exceeding \$10,000.

IF YOU ARE CURRENTLY FULLY INSURED, PLEASE PROVIDE:

 Completed Medical Questionnaires for all employees. (Please photo copy the attached form)**ADDITIONAL INFORMATION REQUESTED:** Census For All Employees Including:

AGE / BIRTHDATE / GENDER / CURRENTLY ENROLLED(y-n) / # DEPs. COVERED / RETIREE (y-n) / COBRA(y-n)

 CURRENT MONTHLY RATES: Single \$ _____ 2 Party \$ _____ Family \$ _____ EMPLOYER CONTRIBUTION: Employee \$ _____ % _____ Family/Dependant \$ _____ % _____**RETENTION LEVEL (Deductible) YOU WOULD LIKE QUOTED:** \$10,000 - 25,000 \$25,000 - 50,000 \$50,000 - 75,000 \$75,000 - 100,000 \$100,000 + Not sure PHYSICIAN NETWORK (PPO) If any: _____**COVERAGE OPTIONS REQUESTED:**
 Medical Dental Vision Perscription
 Short-Term Disability Long-Term Disability Accidental Death 125 (flex) Plans
 PLEASE ATTACH A COPY OF YOUR CURRENT PLAN BENEFIT SUMMARY*Thank you for considering our services!*