



GACS EMPLOYEE BENEFIT PROGRAM QUOTE REQUEST FORM

Member Name: _____ Requested Effective Date: _____

Executive Contact Information: _____ Email: _____
Phone Number: _____ Fax: _____

Benefit Administrator: _____ Email: _____
Phone Number: _____ Fax: _____

Complete Address: _____

Total Eligible Employees: _____ Total Enrolled Employees: _____
Tax ID Number: _____
Years in Business: _____

Corporate Structure of Group: Corporation Sole Proprietor Non-Profit Org.

Benefit Waiting Period: _____

Additional Waiting Period (if applicable) _____

Benefits to Quote:

Medical: HMO (Open Access) Choice POS (Open Access)
 PPO HSA-PPO
 SRC- Limited Benefit Plan

Dental: Employer Paid Voluntary

Life Insurance: Employer Paid Voluntary
 With AD&D Spousal & Dependent Coverage

Short-Term Disability: Employer Paid Voluntary
 14 Day Elimination/24 Week Duration 30 Day Elimination/22 Week Duration

Other:



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PLEASE PROVIDE THE FOLLOWING CHECKED ITEMS BELOW:

Census (Online in Excel format):

- Gender
- Date Of Birth
- Current Salary or Annual Earnings
- Job Title
- Date of Hire: If there are employees in the New Hire Waiting Period, please provide either their Dates of Hire or Dates of Eligibility.
- Employee Plan Selection (HMO/PPO)
- Employee Coverage Tier (EE/ES/EC/FAM)
- **Home** Zip Codes
- Employees Waiving due to Other Coverage or Declining with **No** Other Coverage
- COBRA participants with coverage term date if available. Please provide all census information.
- Retired and Union employees (if applicable).

Current Employer and Employee monthly contribution percentages/amounts, by coverage line

Complete benefit description of each coverage line (e.g. employee booklets)

Rate history for the previous 2 years, by coverage line

Insurance carrier history, by coverage line, for the past two years

Claims History: 2 years for group of 50+ employees

Known large medical claims (\$25k & over) for the past 2 years

Self-Insured Groups:

- Claims Experience: 2 years broken out by month.
- Pooling Point
- Aggregate Corridor
- Contract Basis

Please return the requested items to:

Tamara Tretter

Hunt Insurance Group, LLC / Willis HRH

P.O. Box 12909

Tallahassee, FL 32317-2909

tamara.tretter@willis.com

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