BIAW Health Insurance Program Quote Request

f you are a member of the BIAW and would like to receive information on the available Health Insurance Plans, complete these forms and fax to

Sales Consultants
Capital Benefit Services, Inc.
15375 SE 30th Place, Suite 380, Bellevue, WA 98007

FAX: **(425) 643-6728**
PHONE: **(800) 545-7011 ext. 6**
EMAIL: sales@epkbenefits.com

In order to obtain a quote, our carriers require all sections of this form to be completed.

Group Information

Company Name:	Phone:
Contact Person:	Fax:
Address:	Email:
City, State, Zip:	Date Business Started:
Nature of Business:	SIC Code:

Are you a member of your Local Building Association ? ☐ Yes ☐ No

If yes, please provide: Which Association ? Membership ID#: Member Since:

I authorize the BIAW Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the BIAW Trust.

Authorized Representative: Date:

Current Health Insurance

☐ Group Medical ☐ Group Dental ☐ Individual Policies ☐ None

CURRENT INSURER____________________TRUST / PROGRAM____________________RENEWAL DATE_____________

How long have you been with your current insurer?______________________________

*Please attach a summary of benefits of your current medical (and dental if applicable) plan **or** provide the following:*

Benefit Level (80/20):_________ Copay:_________ Deductible:_________ Rx Benefit:_____________

	CURRENT RATES		RENEWAL RATES	
	Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
Employee				
Spouse				
Single Child				
Children				

What percentage do you pay toward the cost for Employees? ________% **Dependents?**________%

(The company must pay a minimum of 75% for employees, there is no requirement for dependent(s) contribution).

Employee Census

Please include all Eligible Employees; Eligible Employees include all full-time, active employees and owners who have satisfied your company's probationary period for insurance coverage. Please include additional census if your company has 21 or more employees.

SEX M/F	DATE of BIRTH	DEPENDENTS Spouse	1CH	2+CH	SEX M/F	DATE of BIRTH	DEPENDENTS SP	1CH	2+CH