



QUOTE REQUEST - CONFIDENTIAL

Company Name:	Date:									
Street Address: (PO Box, Rural Route, Apartment Number, Lot Number, Street Number and Name, etc.)	Principal Bus. Location (county):									
<table style="width:100%; border: none;"> <tr> <td style="border: none;">.....</td> <td style="border: none;">.....</td> <td style="border: none;">.....</td> </tr> <tr> <td style="border: none; width:33%;">City</td> <td style="border: none; width:33%;">State</td> <td style="border: none; width:33%;">Zip Code</td> </tr> <tr> <td style="border: none;"> </td> <td style="border: none;"> </td> <td style="border: none;"> </td> </tr> </table>	City	State	Zip Code				Phone: Fax:
.....								
City	State	Zip Code								

To determine appropriate benefits and rating: How many employees did the company have in the previous year (calculated by averaging the total number of all employees employed on business days during the preceding calendar year)? Include all employees issued a W-2, and all other common law employees regardless of hours worked or enrollment in the health plan. For example, this would include full-time, part-time and seasonal employees – essentially any individual employed by the employer.

50 or less 51-100 101 or more

1. Has this company filed for bankruptcy? Yes If "Yes", provide date: _____ No
2. Company Headquarter Location: TN GA - Catoosa Co. GA - Dade Co. GA - Walker Co.
Other: _____
3. Are there commonly owned businesses or subsidiaries included as part of this coverage: Yes No
4. Detailed Business Description: _____

Effective Date: _____ Employer Contribution for: Dental _____% Vision _____%

Current MEDICAL Carrier's Name: _____

Current DENTAL Carrier's Name: _____

Benefit Administration Period: Calendar Year Plan Year

Total Eligible: _____ Total Participating in Medical: _____ Total Participating in Dental: _____

Retirees Covered: *Yes No

Is a Health Savings Account (HSA) currently offered? *Yes No

*If yes, are you interested in integration? *Yes No ***(If yes, discuss with your Sales Executive)**

CENSUS REQUIRED: Please complete the appropriate attached census template.

NOTE: Please refer to the BlueCross Group Product Reference Guide for products and plan designs available. Contact your Sales Executive or Regional Sales Office with any questions.

Requested Plan Number or Description: EHB Plan(s) _____ Non-EHB Plan(s) _____

Broker's Name:	Current Broker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Broker Email:	Broker Phone:
Broker's Analyst/Support Name & Email:	

For BlueCross BlueShield of Tennessee Internal Use Only
SIC Code: _____ **Rep #:** _____