# Group Quote Request Form

Return via email to quotes@agchealthplansnw.com
Questions? (866) 873-6175

Date Submitted: ______________________ Eff Date Requested: ______________________

Agent: ______________________ Agent Phone: ______________________

Agency: ______________________ Agent Email: ______________________

Group Name: ______________________ Business Type: __________ SIC: __________

Address: ______________________ Phone: ______________________

City: ST: ZIP: County:

Current AGC Member? Yes ☐ No ☐

| ***Current Coverage*** | Plan 1 | | Plan 2 | | Dental | |
|---|---|---|---|---|---|---|
| Carrier: | | | | | | |
| Renewal Date: | | | | | | |
| Office Visit Copay: | $ | | $ | | Deductible | $ |
| Hospital Copay: | $ | | $ | | Annual Max | $ |
| Deductible: | $ | | $ | | Ortho: | ☐ Yes |
| Coinsurance %: | % | | % | | Coverage | |
| Stop Loss: | $ | | $ | | Preventive: | % |
| Max Out of Pocket: | $ | | $ | | Basic: | % |
| Pharmacy Benefit: | | | | | Major: | % |
| ***Rates*** | Current | Renewal | Current | Renewal | Current | Renewal |
| Employee: | $ | $ | $ | $ | $ | $ |
| E+ Spouse: | $ | $ | $ | $ | $ | $ |
| E+ Children: | $ | $ | $ | $ | $ | $ |
| E+Family: | $ | $ | $ | $ | $ | $ |

***Total Employees:*** ______

Waiving Employees: ______

Ineligible Employees: ______

Out of Area Employees: ______

***Employer Contribution***

Employee: ______ %

Dependents: ______ %

Large Medical/Dental Claims/Experience Information (Required for cases over 100 eligible employees. *Guardian requires 2 years dental experience, rate history and employee count*): ☐ Attached ☐ Not Available

For Office Use Only:

| Date Received in Underwriting: | Date Entered: |
|---|---|