

**Group Quote Request Form**

Return via email to [quotes@agchealthplansnw.com](mailto:quotes@agchealthplansnw.com)

Questions? (866) 298-8264

|  |  |  |  |
| --- | --- | --- | --- |
| Date Submitted: |  | Eff Date Requested: |  |
| Agent: |  | Agent Phone: |  |
| Agency: |  | Agent Email: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Group Name: |  | | | Business Type: | | |  | | SIC: |  |
| Address: |  | | | | | Phone: | |  | | |
| City: |  | State: |  | | ZIP: | |  | | | |
| Current AGC Member? | | Yes  No | | | | |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Current Coverage*** | Plan 1 | | | |  | Plan 2 | | | |  | Plan 3 | | | |
| Carrier: |  | | | |  |  | | | |  |  | | | |
| Renewal Date: |  | | | |  |  | | | |  |  | | | |
| Office Visit Copay: | $ | | | |  | $ | | | |  | $ | | | |
| Hospital Copay: | $ | | | |  | $ | | | |  | $ | | | |
| Deductible: | $ | | | |  | $ | | | |  | $ | | | |
| Coinsurance %: | % | | | |  | % | | | |  | % | | | |
| Max Out of Pocket: | $ | | | |  | $ | | | |  | $ | | | |
| Pharmacy Benefit: |  | | | |  |  | | | |  |  | | | |
| ***Rates*** | | Current |  | Renewal |  | Current |  | Renewal |  | | | Current |  | Renewal |
| Employee: | | $ |  | $ |  | $ |  | $ |  | | | $ |  | $ |
| E+ Spouse: | | $ |  | $ |  | $ |  | $ |  | | | $ |  | $ |
| E+ Children: | | $ |  | $ |  | $ |  | $ |  | | | $ |  | $ |
| E+Family: | | $ |  | $ |  | $ |  | $ |  | | | $ |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Total Employees:*** |  |  | ***Employer Contribution to Premium*** | |
| Waiving Employees: |  |  | Employee: | % |
| Ineligible Employees: |  |  | Dependents: | % |
| Out of Area Employees: |  |  |  | * OR - |
|  | | | Defined Contribution: | $      per employee |