

**The Ohio Chamber Alliance, Inc.
Request for Healthcare Quote**

1. Company Name: _____
2. Address: _____
3. Phone #: (____)_____ Fax #: (____)_____
4. Contact Person: _____
5. Coverage Requested to Quote:
MEDICAL DENTAL RX VISION LIFE STD LTD HMO PPO

6. Current Carrier: _____
7. Current Cost: _____
8. Census: Please complete the attached census form and questionnaires.
9. Rate History: (Last three (3) year period including carrier-insurer.)

10. Average Enrollment for last three (3) year period:

11. COBRA: (Participants eligible? How many? Effective dates.)

12. Retirees: (Advise number and benefit coverage.)

13. Union: (Please provide local number.)

14. Employee contribution: (Percentage or dollar amount.)

15. Quote Due: _____ Follow-up Request Date: _____ Sent: _____

16. Broker Agency: _____

17. Broker Address: _____

18. Sponsor Referral: ___ Yes ___ No

19. Sponsor Name: _____

20. Sponsor Address: _____

21. Remarks: _____

Please enclose a copy of the following:

- last invoice from current carrier
- copy of current plan document

The Ohio Chamber Alliance, Inc.
9066 E. Market Street
Warren, OH 44484
PH: (330) 856-9213 Fax: (330) 856-6662