Phone: 866-297-7729 / Fax: 570-265-7758

Quote / Enrollment Questionnaire

Business Contact Information					
Employer Name:			Contact Person:		
Address:		City:	State:	ZIP:	County:
Phone:	Fax:		Email:		Affiliated Coop:

Current Business and Provider Information:		
Type of Business:		Years in business:
Total # of employees working at least 30hrs / week:		
Total # of employees working at least 20 weeks / calendar year:		
Employer Waiting Period: □ None □ 30day □ 60day □ 90day Other (please specify):		
Current Carrier:		Years with Carrier:
Current Plan: □ HMO □ PPO □ Traditional □ H S A	Current Deductible:	Renewal Date:
Current Broker:	ASA Broker (if applicable):	

Coverage Levels	
E = Employee Only	**W1** = Coverage through spouse
ES = Employee & Spouse	**W2** = Other coverage (not through spouse)
EC = Employee & Child	**W3** = Voluntary Waiver - has no other coverage
F = Family	**W4** = Not eligible due to employer waiting period

Please list ALL FULL TIME employees that fall into an eligible employee class*	Date of Birth	Age	Gender	# of Children	Coverage Level
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					

* If insurance is only offered to certain classes of employees, list only the employees within each class on the application. An example of valid employee class distinctions could be Management and Laborer.

Authorized Signature **Date**

By signing this form I agree that the information is accurate. I also understand that ASA reserves the right to alter the insurance proposal if the final enrollment information differs from the information provided to ASA on this Quote / Enrollment Questionnaire.

Internal Office Use Only		
Step 1: Select Quote Status		
□ Preliminary Quote	□ Final Quote	
Step 2: Select quote type		
□ Request for Standard Underwriting Quote		
□ Request for Standard Composite Quote		
□ Request for Standard Experience Quote		
Step 3: Select appropriate division		
□ ADM AT	□ Inside NY	□ Outside NY
□ ADM BC	□ MEFB AT	□ PA AT
□ ADM GR	□ MEFB BC	□ PA BC
□ DFA	□ MVP	□ PA Rural
□ DFA MKT	□ NHFB	□ Triangle
□ FHCW	□ Ocean Spray	□ VTFB & GM

If Requesting a QUOTE ONLY
Requested Effective Date: / /
Step 1: Choose your carrier
□ BCBS □ Aetna □ MVP
Step 2: Choose your plan type
□ PPO □ HSA □ HDHP (MVP only)
**Step 3: List your deductible choices*, ** **

* Please refer to the application for available deductible options when completing this section.
** If requesting multiple quotes please list each deductible option and the carrier you're requesting i.e. Aetna - $300, $500 $1,000
BCBS - $500, $1,000

Phone: 866-297-7729 / Fax: 570-265-7758

Quote / Enrollment Questionnaire - page 2

If this page is completed then Page 1 with the authorized signature MUST also be submitted

Please list ALL FULL TIME employees that fall into an eligible employee class*	Date of Birth	Age	Gender	# of Children	Coverage Level
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					

Authorized Signature **Date**

By signing this form I agree that the information is accurate. I also understand that ASA reserves the right to alter the insurance proposal if the final enrollment information differs from the information provided to ASA on this Quote / Enrollment Questionnaire.

* If insurance is only offered to certain classes of employees, list only the employees within each class on the application. An example of valid employee class distinctions could be Management and Laborer.