

Current Benefits: Please complete the following and include benefit summaries

HMO:

Plan Name	Copay	Deductible	Hospital	Coinsurance	RX

PPO:

Plan Name	Copay	Deductible	Hospital	Coinsurance	RX

Does the group provide any reimbursement for copays? Yes No

Additional Group/Coverage Information:

Plan	Carrier	Plan Design	Rates			
Dental			EE	ES	EC	EF
Vision			EE	ES	EC	EF
Life						
LTD						

Known health conditions, pregnancies, disabilities, and/or claims over \$15,000?

Date	Diagnosis	Prognosis	Known ongoing treatment

Pregnancies:

Due Date	Multiples	Known Complications
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Five Year Carrier History:

Carrier	Year

Census: Please provide census data. Age or DOB, Gender, Dependent Status, Home Zip Code, Medical Plan Enrollment, Dental Plan enrollment. A template is available at RBGSOCAL.com.