

# NMTA Health Insurance Program Quote Request

If you would like to receive information on health insurance plans, complete both pages and fax to:

**Sales Consultants**  
**Capital Benefit Services, Inc.**  
 15375 SE 30th Place, Suite 380, Bellevue, WA 98007

FAX: (425) 643-6728  
 PHONE: (800) 545-7011 ext. 6  
 EMAIL: [sales@epkbenefits.com](mailto:sales@epkbenefits.com)

In order to obtain a quote, our carriers require all sections of this form to be completed.

**Please let us know how you heard about the MBA Health Insurance Trust**

NMTA 3-11

**Group Information**

Company Name:	Phone:
Contact Person:	Fax:
Address:	Email:
City, State, Zip:	Date Business Started:
Nature of Business:	SIC Code:
Are you a member of the Northwest Marine Trade Association? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide:      Membership ID#	Member Since:
I authorize the NMTA/MBA Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the MBA Trust.	
Authorized Representative:	Date:

**Current Health Insurance**

Group Medical     
  Group Dental     
  Individual Policies     
  None

CURRENT INSURER \_\_\_\_\_ TRUST / PROGRAM \_\_\_\_\_ RENEWAL DATE \_\_\_\_\_

*Please attach a summary of benefits of your current medical (and dental if applicable) plan or provide the following:*

Benefit Level (80/20): \_\_\_\_\_ Copay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Rx Benefit: \_\_\_\_\_

	CURRENT RATES AS OF: _____		RENEWAL RATES AS OF: _____	
	Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
<i>Employee</i>				
<i>Spouse</i>				
<i>Single Child</i>				
<i>Children</i>				

What percentage do you pay toward the cost for Employees? \_\_\_\_\_ % Dependents? \_\_\_\_\_ %  
 (The company must pay a minimum of 75% for employees, there is no requirement for dependent(s) contribution).

**Employee Census**

Please include all Eligible Employees; Eligible Employees include all full-time, active employees and owners who have satisfied your company's probationary period for insurance coverage. Please include additional census if your company has 21 or more employees.

SEX M/F	DATE of BIRTH	DEPENDENTS			SEX M/F	DATE of BIRTH	DEPENDENTS		
		Spouse	1CH	2+CH			SP	1CH	2+CH

