



Regence BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Quote Request

I'd like to receive a free, no-obligation rate quote for medical and dental coverage for an effective date of _____.

Please send it to:

- Company Contact Person
- Broker

Via:

- E-mail
- Fax
- Mail

Please tell us about your company:

| | | | |
|--|---|---------------------|---------------------|
| Company Name | Contact Person | | |
| Type of Business | SIC Code (if known) | Number of Employees | |
| Street Address | City | State | ZIP Code |
| County Where Company is Located | Phone Number | Fax Number | |
| E-mail Address | Percent of Premium Company Pays | | |
| | Employee Medical | % | Dependent Medical % |
| | Employee Dental | % | Dependent Dental % |
| Current Carrier of Group Medical Plan | Current Carrier of Group Dental Plan | | |
| Current Group Benefits (e.g., PPO, Vision, Rx) | If Regence is a Current Carrier, Group Number | | |
| Broker's Name (if any) | Broker Number (if known) | | |
| Broker's Email Address | Broker's Phone Number | Broker's Fax Number | |

Please list employees who will be covered:

| | Employee Name | Date of Birth or Age* | Sex* | Home ZIP Code | Spouse to be Covered?* | Spouse's Date of Birth or Age | Number of Children to be Covered* | Children's Dates of Birth or Ages |
|-----|---------------|-----------------------|------|---------------|------------------------|-------------------------------|-----------------------------------|-----------------------------------|
| Ex. | Maria Hart | 4/10/62 | F | 98116 | Y | 8/22/61 | 3 | 14, 11, 9 |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
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| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

*Required fields

We can provide a more accurate quote with complete information. For over 10 employees, please attach additional sheet(s). If you have questions, please give us a call at 1-800-653-1125.