SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.622.7790 | TTY 711

Large and Small Employer

Employer Group Quote Request

A. General

Employer legal name _____ DBA _____

Physical address *(PO box not accepted)*: _____

City _____ State _____ ZIP _____ County _____

Phone _____

Business type: ☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

SIC code or nature of business _____ Federal tax ID number _____

1. **Does your business have multiple locations:** ☐ Yes ☐ No If yes, list the city and state of each location:

   City _____ State _____ County _____

   City _____ State _____ County _____

2. **List the names of the businesses with common ownership (where an owner owns 50% or more of more than one business) that are applying for coverage as part of this offering:**

Company name	Company address (street, city, state)	No. of employees	Federal Tax ID Number

B. Eligibility and Health Plan information

1. **Are any classes of eligible employees to be excluded from coverage:** ☐ Yes ☐ No

   If yes, identify and explain each class _____

   Attach a copy of the group's most recent Quarterly Wage and Tax Statement.

Total no. of employees	Total no. of eligible employees	Total no. of employees enrolled

2. **Are you currently insuring retirees:** ☐ Yes ☐ No

3. **What percentage of the monthly premium is to be paid by the employer for each of the following coverages (each must be at least 25%):**

   Single _____ Employee and spouse _____ Employee and children _____ Full family _____

C. Continuation/Disability

1. **Provide the following details for any employee that is not currently active at work. For each employee choose from the following list to indicate the reason they are not actively working** ***(If you have policies pertaining to any of the reasons listed below, provide a copy):***

Name	Last day at work	Anticipated return to work or coverage end date	Reason code	**Reason codes:** a. Currently on COBRA or State Continuation, within election period b. Laid off c. Medical leave of absence d. Non-medical leave of absence e. Military leave f. Health coverage through severance agreement e. Receiving Worker's Compensation

If you need more space, attach an additional sheet.

D. HRA/HSA information

1. **Do you offer an HRA:** ☐ Yes ☐ No Contribution amount in percent or dollars: Single _____ Family _____
2. **Do you offer an HSA:** ☐ Yes ☐ No Contribution amount in percent or dollars: Single _____ Family _____

E. Current coverage

1. **Are you replacing existing group health coverage:** ☐ Yes ☐ No

   Current group insurance carrier/administrator _____ Effective date _____

   Reason for changing carriers/administrators _____

   Attach a copy of the most recent bill from the prior carrier or administrator.

F. Independent agent certification *(if applicable)*

With respect to the application for Security Health Plan of Wisconsin, Inc. coverage made

by _____ represented by _____

and signed on _____ , I hereby certify and represent all of the following as being true:

- I hereby certify that I have actively participated in the solicitation and placement of this insurance.
- I understand that I have no authority to alter this application, to bind Security Health Plan by making any promise and/or representations, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Security Health Plan.

_____ _____
Writing agent signature Date *(m/d/y)*

_____ _____
Agent name *(print)* Agency

Are you currently the agent of record for this employer: ☐ Yes ☐ No

Return form by email at shpacctcoord@securityhealth.org or by fax at 715-221-9456.

