

CBAI

HEALTH INSURANCE *REQUEST FOR QUOTE* PROCESS

Please provide the following information so that we may shop your group and do cost and benefit comparisons.

1. Summary of current benefits (copy)
2. Census form completed (see attached)
3. What portion of the premium does the bank pay?
Employee _____ Dependents _____
4. Provider Network used currently (please list any specific hospitals or doctors that must be in the network)

5. A copy of your most recent billing from your current carrier (we require this to complete a full comparison of benefits along with rate differences)
6. A one page medical history completed by each covered employee (see attached, this will allow us to get a more accurate rate based on the groups medical history)

Please be very thorough in completing the medical history page. The more information we have in advance the more accurate our quotes will be.

*If you have any questions or need further explanation please contact
Penny Cheshier (pennyc@cba.com) or call 800/736-2224*

GENERAL INFORMATION

Bank Name: _____

Contact Person: _____

Present Plan Carrier: _____

Life Insurance Flat Amount: \$ _____

OR

_____ 1x _____ 2x _____ 3x

Other Coverage: Life: Yes _____ No _____

Dental Plan: Yes _____ No _____

Orthodontia: Yes _____ No _____

Long Term Disability: Yes _____ No _____

Short Term Disability: Yes _____ No _____

CENSUS INFORMATION

	Name	Sex	Employee DOB mm/dd/yy	Spouse DOB mm/dd/yy	Dependent Status			Annual Earnings**
					E	S	#C	
	(Example) John Doe	M	10/20/55	02/10/58	X	X	2	
1								
2								
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* Dependent Status – (E) Employee / (S) Spouse / (#C) Number of Children

** Annual earnings needed to quote Stand Alone Life, STD, LTD

Is there anyone on your plan that is NOT a full time employee? Yes _____ No _____

RETURN TO:

CBIS, Employee Benefits ~ 901 Community Drive ~ Springfield, IL 62703 ~ Fax# 217/529-9484

MEDICAL QUESTIONNAIRE

Name: _____ Male Female

Date of Birth: _____

How many children are you insuring, if any? _____

Coverage Type (please circle): **Employee** **Emp/Spouse** **Emp/Child** **Family**

Employee: Height _____ ft. _____ in. Weight _____ lbs.

Spouse: Height _____ ft. _____ in. Weight _____ lbs.

1. yes no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine, or is anyone pregnant? (Due Date _____ complications _____)

2. yes no In the past 5 years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? Check **ALL** that apply. If a condition is not noted, please list it.

- Cancer Alcohol/Drug Use Arthritis/Bone/Joint/Muscle Skin/Eye/Ear/Nose/Throat
- Infertility Heart/Circulatory Allergy/Asthma/Respiratory Kidney/Bladder/Urinary
- Tumor Liver/Hepatitis Digestive/Intestinal/Eating Stroke/Neurological/Nervous System
- Endocrine Mental/Nervous Other _____
- High Blood Pressure – last reading and date _____ / _____
- Diabetes – last HbA1c reading and date _____ / _____
- Acquired Immune Deficiency Syndrome (AIDS) Infection with HIV (Human Immunodeficiency Virus)/Other Immune Disorder

Name/Relationship	Date diagnosed/treated	Diagnosis of illness or condition
Type of treatment/names of all medications		Any current symptoms or problems

Name/Relationship	Date diagnosed/treated	Diagnosis of illness or condition
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If more space is needed, please continue on back or attach separate page.

Your Signature X _____ Date Signed _____