

KEATING INSURANCE SERVICES, LLC

Group Quote Request

Group Information	Broker Information
Name	Name Keating Insurance Services, LLC
Address	Phone (520) 575-8387
Address	Fax (520) 797-0332
City	Email tom-keating@comcast.net

Requested Benefits

Ancillary Only

Medical		Out of Pocket		Dental		Ancillary	
Plan	Deductible			Plan		Group	Voluntary
HMO <input type="checkbox"/>	250 <input type="checkbox"/> 1000 <input type="checkbox"/>	5,000 <input type="checkbox"/>		Indemnity <input type="checkbox"/>		Vision <input type="checkbox"/>	<input type="checkbox"/>
PPO <input type="checkbox"/>	500 <input type="checkbox"/> 1500 <input type="checkbox"/>	10,000 <input type="checkbox"/>		PPO <input type="checkbox"/>		STD <input type="checkbox"/>	<input type="checkbox"/>
POS <input type="checkbox"/>	750 <input type="checkbox"/> 2000 <input type="checkbox"/>			DMO <input type="checkbox"/>		LTD <input type="checkbox"/>	<input type="checkbox"/>
HSA <input type="checkbox"/>	<input type="checkbox"/> HSA <input type="checkbox"/>			Voluntary <input type="checkbox"/>		Life \$ <input type="checkbox"/>	<input type="checkbox"/>

Specific Carriers Requested:

Current Information

Number of Employees		Employer Contribution %	Renewal Date		Employees in
Total		EE	Current		Arizona <input type="checkbox"/>
Eligible		Dependents	Desired		Out of State <input type="checkbox"/>
Participating					# of Locations <input type="text"/>
Cobra (included in totals)		Nature of Business	SIC Code Yrs in Business		
Carve Out	Y / N	Current Carrier	Yrs with Carrier		
Waiting Period		Previous Carrier	Yrs with Carrier		

Current Rates	Medical				Dental		Vision		Other	
	HMO		PPO/POS/HSA		Current	Renewal	Current	Renewal	Current	Renewal
	Current	Renewal	Current	Renewal						
EE										
EE/SP										
EE/CH										
EE/SP/CH										

Current Benefits	Medical		Dental		Ancillary
	HMO	PPO/POS			
Phys Co-Pay			Deductible		Life/AD&D <input type="checkbox"/>
Deductible			Plan Design		Amount \$ <input type="text"/>
Co Ins			Calendar Yr Max		Dep Life <input type="checkbox"/>
OOP Max			Ortho Included		Vision <input type="checkbox"/>
Family Max					STD <input type="checkbox"/>
RX Co-pay					LTD <input type="checkbox"/>
Hosp Co-pay					Sec 125 <input type="checkbox"/>

If you are aware of any employee in your group who has any of the conditions listed below, please mark accordingly.

Arthritis <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Kidney Disorder <input type="checkbox"/>	Open Hrt Surg <input type="checkbox"/>	Alcohol or Drug Abuse <input type="checkbox"/>
Back/Neck <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Lung Disorder <input type="checkbox"/>	Organ Transplt <input type="checkbox"/>	Other <input type="checkbox"/>
Cancer <input type="checkbox"/>	Heart Disorder <input type="checkbox"/>	Lupus <input type="checkbox"/>	Pregnancies <input type="checkbox"/>	<input type="checkbox"/>
Cardiac Tests <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>	MD <input type="checkbox"/>	Psych Disorder <input type="checkbox"/>	<input type="checkbox"/>
Crohns Disease <input type="checkbox"/>	Hypertension <input type="checkbox"/>	MS <input type="checkbox"/>	Stroke <input type="checkbox"/>	<input type="checkbox"/>

IN ADDITION, each employee and dependent enrolling for health coverage including those continuing on COBRA should complete a health history form

KEATING INSURANCE SERVICES, LLC

Group Census Data

	Gender (M) or (F)	DOB	Coverage Requested					WV*	NC**	Spouse Age	# of CH	Home Zip Code	***Occupation	***Monthly Salary	On COBRA
			EE only	EE+ SP	EE+ CH	EE+ FM	EE+ FM								
1															
2															
3															
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*WV = Eligible employees who are waiving coverage
 **NC = Not eligible for coverage (i.e. part time or waiting for enrollment)
 *** = Salary and Occupation are only needed for Disability Quote.

KEATING INSURANCE SERVICES, LLC

Health History Questionnaire

Each employee and dependent enrolling for health coverage including those continuing with COBRA should complete this form.

	Gender	DOB (Age)	Height	Weight	Smoker (Yes/No)
Employee	M F	_____	_____	_____	_____
Spouse	M F	_____	_____	_____	_____
Dependent 1	M F	_____	_____	_____	_____
Dependent 2	M F	_____	_____	_____	_____
Dependent 3	M F	_____	_____	_____	_____
Dependent 4	M F	_____	_____	_____	_____
Dependent 5	M F	_____	_____	_____	_____

Yes	No	Question's	EE	SP	DEP #
<input type="checkbox"/>	<input type="checkbox"/>	1 Is anyone currently ill?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	2 Is diagnostic testing, an operation or any future treatment being recommended or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	3 Is anyone pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	4 Is anyone taking any medication. If "Yes", list all medications and dosages.	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medication	Dosage	Taken for Treatment of

Yes	No	Within the past 10 YEARS have any individuals been diagnosed with or treated for:	EE	SP	DEP #
<input type="checkbox"/>	<input type="checkbox"/>	5 Chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels circulatory system? or been diagnosed treated for stroke, TIA (mini-stroke) or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	6 Psychological or mental disorder, emotional or nervous disorder, or depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	7 Cancer, tumor or other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	8 Kidney or other organ disorder or have had or have been recommended to have an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	9 Emphysema, other respiratory or lung diseases or breathing conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	10 Having AIDS or HIV or other immune system disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	11 Diabetes? If Yes, give date of diagnosis and whether insulin or non-insulin Please include dosage of insulin and any related problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	12 Arthritis? If yes, specify type, extent of disability and treatment received.	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	13 Been confined in a hospital, clinic, sanitarium or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	14 Back or neck problems including spinal manipulation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	15 Crohns Disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	16 Lupus?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	17 MD or MS?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	18 Drug or Alcohol Abuse?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	19 Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	20 Other?	<input type="checkbox"/>	<input type="checkbox"/>	_____

For any "YES" answers identified above, please provide complete details below. Use additional sheet if needed.

Question Number	Illness or Diagnosis	Date of Diagnosis	Date and Type of Treatment	Prognosis

Signature: _____

Date: _____