Submit to:
Affinity Benefit Services
1300 efferson Street
Suite 206
Des Plaines, IL 60016

P 866-641-8836
F 866-524-1412

Legal Name: Brunswick Dealer Advantage Benefit Trust
Version: AC / RFQ / 04/09

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REQUEST FOR QUOTE

So that we may provide you with the most competitive quotes, please complete this fillable form. Then save it, print it, sign it and fax it back to the number shown above.

SECTION I. GENERAL INFORMATION

Company Name: ______________________ Date: ______________ *(mm/dd/yyyy)*

Street Address: ______________________

City: ______________________ State: ________ Zip: ____________

Administrative Contact: ______________________ Title: ______________

Telephone: ______________ Fax: ______________ E-mail: ______________

SECTION II. GROUP INFORMATION

1. No. of employees: *Full Time ________ Part Time ________ *Hours required for full-time status ________
2. Current Participants: Full Time ________ Part Time ________ COBRA ________ Other ________
3. Waiting period for new employees: First day of the month following ______ days of employment.
4. Employer Contributions: ________ % of employee ________ % of employee dependents

SECTION III. CURRENT COVERAGE (Please attach a copy of your current Schedule of Benefits)

1. Current Providers
   Medical: ______________________ No. Years: ________
   Dental: ______________________ No. Years: ________
   Vision: ______________________ No. Years: ________
2. Renewal Date: ______________ *(mm/dd/yyyy)*
3. Projected Effective Date: ______________ *(mm/dd/yyyy)*
4. Type of Plan: ☐ PPO ☐ HMO ☐ Other ______________
5. Prescription Drug Coverage

   Deductible: $ ________
   Co-payments: $ ________ Generic $ ________ Formulary $ ________ Non-Formulary

6. Has coverage ever been non-renewed? ☐ Yes ☐ No If yes, please explain ______________________

7. Is your coverage: ☐ Fully Insured ☐ Partially Self-funded

8. Insurer and Rate History: (Please attach a copy of current invoice)

	Current Year	1st Prior Year	2nd Prior Year
Insurer:			
Employee:	$	$	$
Employee & Spouse:	$	$	$
Employee & Child(ren):	$	$	$
Employee & Family:	$	$	$

9. Have your benefits changed in any year listed above? ☐ Yes ☐ No
If yes, please include a copy of the change and note the year changed.

SECTION IV. MEDICAL INFORMATION

This section is designed to assist us in obtaining information necessary to evaluate your group. Please answer the questions to the best of your knowledge for the persons to be insured (employees, spouses, and dependent children). If the answer to any of the following questions is "yes," please use the additional space provided and if necessary, an additional sheet if needed to explain.

1. Are you aware of any employee or dependent who has been treated, hospitalized or had surgery for a serious illness, physical or mental disorder, including but not limited to, cancer, AIDS, diabetes, cardiovascular disease, organ transplant, alcoholism, drug abuse, obesity etc.?
   ☐ No
   ☐ Yes ______________________________

2. Are you aware of any employee or dependent who has a hospitalization or surgery pending or has been advised that hospitalization or surgery is necessary?
   ☐ No
   ☐ Yes ______________________________

3. Are you aware of any employee or dependent who is currently disabled or not actively at work because of illness or injury?
   ☐ No
   ☐ Yes ______________________________

4. Are there any employees or dependents on COBRA? If yes, please describe any major medical situations, the qualifying event and the date of the qualifying event.
   ☐ No
   ☐ Yes ______________________________

5. Are there any employees or dependents with an existing pregnancy?
   ☐ No
   ☐ Yes ______________________________

6. If "yes," are multiple births expected?
   ☐ No
   ☐ Yes ______________________________

7. Are there any handicapped children who have passed the limiting age and are currently insured by the present carrier?
   ☐ No
   ☐ Yes ______________________________