

REQUEST FOR QUOTATION - MA

FOR GROUPS OF 5 - 50 ELIGIBLE EMPLOYEES

In order for Tufts Health Plan to provide a quote for your company, please complete this form and return it as soon as possible to: colleen_stankard@tufts-health.com.

Company name: _____	Date Received: _____
Address: _____	Total # of Eligibles: _____
Zip Code: _____	Desired Effective Date: _____
Telephone #: _____	Date Requested to Rep: _____
Fax #: _____	Employer Contributions:
E-mail address: _____	Ind: _____ Fam: _____
Contact name: _____	Comments: _____
Broker name: _____	_____

Present Carriers	Ind Rates (Current)	Fam Rates (Current)	Ind Rates (Renewal)	Fam Rates (Renewal)	Plan Description
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

EMPLOYEE CENSUS DATA

Please list all employees who are eligible for group health care benefits. **If an employee is eligible, but waives coverage through your group plan, please indicate the reason in the "Reason for Waiver" column.** Please document all employees covered through spousal coverage under "Reason for Waiver" as well.

Coverage Key

Subscriber 1 Subscriber and Spouse 2 Subscriber and Child 3 Subscriber and Children 4 Family 5

Employee Name or Code	DOB	Coverage	M/F	Reason for Waiver	Zip Code
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					