

INSTRUCTIONS

For a no-obligation rate quote, complete the form below and email to **kaiser.sbu.sales@kp.org**. Please list all employees who are eligible for health care benefits.

COMPANY INFORMATION

Company name

Street address (no P.O. boxes)

City	State	ZIP	County
Office phone () -	Ext.	Fax () -	
Number of employees who are eligible for health coverage		Current carrier	

BROKER INFORMATION

Firm name			Kaiser Permanente firm ID		
Agent name			Agency license #		
Office phone () -	Ext.	Fax () -	Cell phone () -	Email	
Street address		City		State	ZIP

STRATEGY (OPTIONAL)

☐ Sole Carrier ☐ Slice ☐ Multiple Plan Offering ☐ Account-Based Plans ☐ Workforce Health

EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION*

List all employees, owners, and dependents you'd like quoted. A dependent is a spouse, domestic partner, child or domestic partner's child. Use additional page, as needed.

*For each employee/dependent listed, all fields must be filled out completely to process this form.

First name	Last name or initial	Date of birth (mm/dd/yyyy) or age	Home ZIP	Relationship (check one)		
				<input type="checkbox"/> Employee/owner	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
				<input type="checkbox"/> Employee/owner	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
				<input type="checkbox"/> Employee/owner	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
				<input type="checkbox"/> Employee/owner	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child

*(continues on page 2)***CONTACT INFORMATION**

For more information, please contact Kaiser Permanente at **800-789-4661**, option 2.

**EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION*** *(continued from page 1)*

Company name

*For each employee/dependent listed, all fields must be filled out completely to process this form.

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