# **Small Group Quote Request Form**

**Section 1: Agent information** 



Today's date

PrevRx WH

Health care plans and Dental Net® plans offered by Anthem Blue Cross.

Dental PPO and Vision plans offered by Anthem Blue Cross Life and Health Insurance Company.

Product offerings are subject to regulatory review and approval.

Instructions: Complete the following quotes for groups of 1–100 eligible employees to receive a proposal within two business days.

- Send this form as an attachment in an email to Connect@anthem.com.
- For information on benefits and/or underwriting, please contact Agent Support at 833-747-1190.
- For specialty related questions please reach out to **Connect@anthem.com** or 877-567-1802.

Agent name				Anthem agent no. CA			CA lice	A license no.			
Street address				City				State	ZIP code		
Phone no. Email address											
ection 2: Employe	r information										
Employer name Group/Case					10.	Group SIC code F		For	Form 5500 ID no.		
(if know					(required)				(if applicable)		
Street address (principal business address ¹)						City			Sta	ite	ZIP code
County										tal number of eligible	
Current Medical ca	rrier (if applica	able)	Current	Dental carrier (i	if applicab	ole)		Current Vis	•	•	applicable)
Please include curi	ront rotes and	nlan infar	otion with	n proposal ros	uoot						
Please include curi	ent rates and	pian iniorm	ation with	i proposai requ	iest.						
Section 3: Health p	lans Please se	elect plans o	options(s)	):							
Would you like to											
If yes, an additiona					he group.						
Would you like to											
PPO:	Anthem Platinum Anthem Gold								An	Anthem Bronze	
Prudent Buyer	□ 5/200/1	5%	□ 5/1	500/30%	[		45/1750/4	0%		40/62	00/40%
PPO Network	□ 5/200/1	5% WH	□ 25/	30%	[		45/1750/4	0% WH		60/68	50/40%
	□ 15/40/1	0%	□ 30/	500/20%			50/2200/4	0%		70/66	00/35%
	□ 15/250	/10%	□ 30/	750/20%			55/1950/3	5%		75/73	00/40%
	□ Virtual	Access	□ 35/	500/25%			55/2500/4	5%		4600/	50%
	20		□ 35/	500/25% WH			55/2500/4	5% WH		6000/-	45% w/HSA
			□ 35/	1000/20%			2300/3400	/4600 30%		PrevR	
			□ 35/	1000/20% WH			PrevRx <sup>2</sup>			6000/-	45% w/HSA
				00/3400/3800 1	5%		2600/3400	/5200 35%		PrevR	x WH
				vRx <sup>2</sup>			PrevRx <sup>2</sup>			6700/	0% w/HSA
			□ Virt	tual Access 25/	1000		Virtual Acc	ess		PrevR	х
			□ Virt	tual Access 30			50/3200			6700/	0% w/HSA

Virtual Access 10/1500

### Section 3: Health plans (continued)

PPO:	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze	
Select PPO	□ 5/200/15%	□ 5/1500/30%	□ 45/1750/40%	□ 40/6200/40%	
Network	□ 15/10%	□ 25/30%	□ 45/1750/40% WH	□ 60/6850/40%	
	□ 15/40/10%	□ 25/350/20%	□ 50/2200/40%	□ 70/6600/35%	
	□ 15/250/10%	□ 30/500/20%	□ 55/1950/35%	□ 75/7300/40%	
	□ Virtual Access 20	□ 30/750/20%	□ 55/2500/35%	□ 4600/50%	
		□ 35/500/25%	□ 55/2500/45%	□ 6000/45% w/HSA	
		□ 35/1000/20%	□ 2300/3400/4600 30%	PrevRx	
		□ 1900/3400/3800 15%	PrevRx <sup>2</sup>	□ 6700/0% w/HSA	
		PrevRx <sup>2</sup>	□ 2600/3400/5200 35%	PrevRx	
		□ Virtual Access 25/1000	PrevRx <sup>2</sup>	□ 7200/0% w/HSA	
		□ Virtual Access 30	☐ Virtual Access		
		□ Virtual Access 10/1500	50/3200		
		nore than one PPO network. At enrol			
•		elect PPO network can be offered alo PO network. Not all network options	= -	PPO network, but they cannot	
HMO:			□ 55		
CaliforniaCare	□ 25	□ 35	□ 60/2500/45%		
HMO Network	□ 30	□ 35/500/20%	00/2300/43 /0		
	□ 30	□ 35/1250/20%			
		U 33/1230/20 /0			
HMO: Select	□ 20	□ 30	□ 55		
HMO Network	□ 25	□ 35	□ 60/2500/45%		
	□ 30	□ 35/500/20%	□ 60/2500/45% WH		
		□ 35/1250/20%			
HMO: Small	□ 20	□ 30			
Group Priority	□ 25	□ 35			
Select HMO	□ 30	□ 35/500/20%			
Network		□ 35/1250/20%			
HMO: Vivity	□ 15	□ 25			
	□ 15 WH	□ 25 WH			
		□ 25/500			
		□ 25/500 WH			
		□ 35/1000			
		□ 35/1000 WH			
		□ 35/1850			
		□ 35/1850 WH			
For HMO plans, you o	can request a quote for more	than one HMO network. At enrollme	nt, the group will be required to a	choose only one HMO network	

For HMO plans, you can request a quote for more than one HMO network. At enrollment, the group will be required to choose only one HMO network option. (For example, plans on the Select HMO network can be offered alongside other plans on the Select HMO network, but they cannot be offered alongside plans on the CaliforniaCare HMO Network. Not all network options are available in every area.) Not all network options are available in every area. Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment, the network or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan the employee may be assigned to or be required to choose a different provider, network, and/or plan.

## Section 4: Dental plans<sup>3</sup>

Metallic Dental C	•	lans						
I am requesting a	quote for:	□ Ortl	ployer Sponsored hodontia plant Coverage	<ul> <li>□ Voluntary</li> <li>□ Without Orthodontia</li> <li>□ Without Implant coverage (for Dental Net 3000 plans)</li> </ul>				
Plan name:				Contract code:				
				Contract code:				
				_ Contract code:				
Plan name:								
Oral Surgery service	es if considered M	lajor) and Ortho	odontia if applicable. Wa	niting periods are waived fo	eriod applied to Major services, (Endo, Perio, r existing members if the group has prior d. Orthodontia benefits have a separate ortho			
Section 5: Vision	plans — Visior	benefits are	available for Small (	Groups. Check all that a	apply. <sup>4</sup>			
	•		sored 🗆 Voluntary vision pediatric essen	itial health benefits.				
Plan name:				_ Contract code:				
				_ Contract code:				
Plan name:				_ Contract code:				
Please provide en Last name	nployee(s) deta	ils and/or atta First name	ach a census.	Sex Date of Birth (MMDDYYYY)				
· · ·				years or older				
Last name		First name		Sex	Date of Birth (MMDDYYYY)			
Relation:     Employee   Spouse			<ul><li>Child, 14 years old or younger</li><li>Child, 15 years or older</li></ul>					
Last name		First name		Sex	Date of Birth (MMDDYYYY)			
Relation:	□ Empl	•		vears old or younger vears or older				
Last name		First name		Sex	Date of Birth (MMDDYYYY)			
Relation:	. ,			years old or younger years or older				

Last name		First name			Sex	Date of Birth (MMDDYYYY)			
Relation:					years old or younger years or older				
Last name		First name			Sex	Data of Pirth (MMDDVVVV)			
Last Hallie		riistiiaiile			Sex	Date of Birth (MMDDYYYY)			
Relation:	elation:     Employee			☐ Child, 14 years old or younger					
	□ Spouse		☐ Child, 15 years or older						
		I							
Last name		First name			Sex	Date of Birth (MMDDYYYY)			
Relation:	☐ Employee ☐ Child, 14			Child, 14 y	years old or younger				
		se		Child, 15 y	ears or older				

- 1 The principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the State where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.
- 2 These plans have a different per member deductible amount depending on whether the subscriber is enrolled as self only, or has enrolled dependents within the plan. Plans have been designed in this manner to comply with both AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high-deductible health plans.
- 3 For dental plans, you may request a quote for both contribution options, employer paid and voluntary. At enrollment, the group will be required to choose only one contribution option.
- 4 For vision plans, you may request a quote for both contribution options, employer paid and voluntary. At enrollment, the group will be required to choose only one contribution option.

## Send this form as an attachment in an email to Connect@anthem.com

Attach additional sheets, if needed.

Ask your Sales Account Executive or the Connect team for details on discounts for multiline purchases.

#### For additional Information

https://www.anthem.com/ca http://www.anthem.com/ca/specialty