PIEDMONT COMMUNITY HEALTHCARE, INC.

1937 Thomson Drive, Lynchburg, VA 24501
Fax (434) 947-3670

GROUP QUOTE REQUEST
26+ Employees

Broker Information

Broker Name:	Agency:	
Telephone #:	Fax #:	Email address:

Group Information

Please attach a complete census with this quote request.

Group Name			
City/County			Zip
Multi-Location Group? ____Yes ____No	# Locations	Address (Please list locations on additional sheet)	
# Years in Business	Nature of Business		Industry Code

Type of Organization	☐ C-Corporation	☐ Limited Liability Company	☐ Nonprofit Organization
	☐ S-Corporation	☐ Independent Contractor	☐ Other

# Total Employees	# Full Time Employees	# Part Time Employees	# Applying (Including those in waiting period)
# Waiving Coverage	# Out Of Area Employees	# Hours per week to be considered eligible	Effective Date

Benefit Products to Quote

Please use product quote form.

List Names of employees/dependents currently on COBRA/Continuation (If not enough space, please attach sheet)

Name of Current Medical Carrier	# Years	Name of Current Dental Carrier	# Years
Description of Current Medical/Prescription Benefits		Description of Current Dental Benefits	
Employer Medical Contribution Single _____% Family _____%		Employer Dental Contribution Single _____% Family _____%	
Worker's Compensation Carrier	List Owners/Partners not covered by Workers Comp		

Yes ☐ No ☐		In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
Yes ☐ No ☐		In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?

Under federal law, if your group had 20 or more employees or at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had less than 20 employees, you must provide State Continuation.

Please Check one: State Continuation _____ COBRA Continuation ______

Under federal law, if your group had 20 or more employees or at least 50% of the employer's working days of the preceding calendar year, health plan benefits would be primary. If your group had less than 20, Medicare Benefits would be primary.

Please Check one: Medicare Primary _____ Health Plan Primary ______

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GROUP RISK PROFILE
26+ Employees

Medical Profile

Please answer the following questions to the best of your knowledge for all eligible employees and dependents.
Please provide details to "Yes" answers in the space provided.
IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your current plan.

Yes ☐ No ☐ 1. Have any employees or dependents been diagnosed or treated during the past 5 years for any of the following conditions?

☐ Heart Disease	☐ Stroke	☐ Diabetes
☐ Epilepsy or Seizures	☐ Kidney Disease/Failure	☐ Spine, Disc, Joint or Bone Disorder
☐ Chronic Lung Disorder	☐ Cancer	☐ AIDS/HIV
☐ Drug/Alcohol Abuse	☐ Mental/Nervous Disorder	☐ Muscular Dystrophy
☐ Multiple Sclerosis	☐ Lupus	☐ Rheumatoid Arthritis
☐ Congenital Disorder	☐ Growth Hormones	☐ Intestinal Disorders
☐ Liver Disorder	☐ Organ Transplants	☐ Connective Tissue Disorder
☐ Gall Bladder Disease	☐ High Blood Pressure	☐ Ulcers or Stomach Disorder
☐ Blood Disorders	☐ Occupational Therapy	☐ Prosthetic Device
☐ Colitis or Intestinal Disorder	☐ Physical Therapy	☐ Thyroid or Goiter
☐ Developmental Delay	☐ Speech Therapy	☐ Paralysis
☐ Endometriosis	☐ Non-cancerous Tumor or Growth	☐ Chronic Disease of Eye, Ear, Nose, and Throat
☐ Infertility		

Yes ☐ No ☐ 2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births.

Yes ☐ No ☐ 3. Have any employees or dependents been hospitalized or had any surgical operations during the past 5 years?

Yes ☐ No ☐ 4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?

Yes ☐ No ☐ 5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

Yes ☐ No ☐ 6. Are any employees or dependents receiving disability benefits of any type, including Social Security Income, Worker's Compensation, Medicare, and Medicaid?

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets.

Question #	Relationship	Birthdate	Treatment Dates	Condition	Claim $ Amount	Prognosis & Current Treatment, Including Prescriptions

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, Company shall notify Insurer promptly of any significant changes in health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under this policy.

I represent to the best of my knowledge the information I have furnished is accurate and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations, or misstatements in the information requested on this form can result in the voiding or reformation of insurance.

Signature

Signature____ Date____________ Title____________________________

LocalSelect™

Product Options

Please Select No More Than 5 Plans

PIEDMONT COMMUNITY HEALTH PLAN

Piedmont Plans

X	PPO	X	POS	Name	Coins	Ded/ Co-pay	Form#
	PPO		POS	Piedmont	Preferred	200/20	IPPIEDP20020
	PPO		POS	Piedmont	Preferred	500/25	IPPIEDP50025
	PPO		POS	Piedmont	Basic	500/25/40	IPPIEDB5002540
	PPO		POS	Piedmont	Complete	1000/25	IPPIEDC100025
	PPO		POS	Piedmont	Preferred	1000/25	IPPIEDP100025
	PPO		POS	Piedmont	Complete	1500/25	IPPIEDC150025
	PPO		POS	Piedmont	Advantage	1500/25	IPPIEDA150025
	PPO		POS	Piedmont	Preferred	1500/25	IPPIEDP150025
	PPO		POS	Piedmont	Basic	1500/25/40	IPPIEDB15002540
	PPO		POS	Piedmont	Preferred	2000/25/35	IPPIEDP20002535
	PPO		POS	Piedmont	Basic	2000/25/40	IPPIEDB20002540
	PPO		POS	Piedmont	Complete	2500/25	IPPIEDC250025
	PPO		POS	Piedmont	Preferred	2500/25	IPPIEDP250025
	PPO		POS	Piedmont	Preferred	2500/30	IPPIEDP250030
	PPO		POS	Piedmont	Preferred	3000/25/40	IPPIEDP30002540
	PPO		POS	Piedmont	Basic	3000/25/40	IPPIEDB30002540
	PPO		POS	Piedmont	Complete	3500/25/40	IPPIEDC35002540
	PPO		POS	Piedmont	Complete	5000/25/40	IPPIEDC50002540
	PPO		POS	Piedmont	Basic	5000/25/40	IPPIEDB50002540

Partners Plans

X	PPO	X	POS	Name	Coins	Ded/ Co-pay	Form#
	PPO		POS	Partners	Preferred	0/25/45	IPPARTP02545
	PPO		POS	Partners	Preferred	200/20	IPPARTP20020
	PPO		POS	Partners	Preferred	500/25	IPPARTP50025
	PPO		POS	Partners	Basic	500/25/40	IPPARTB5002540
	PPO		POS	Partners	Complete	1000/25	IPPARTC100025
	PPO		POS	Partners	Preferred	1000/25	IPPARTP100025
	PPO		POS	Partners	Preferred	1000/30	IPPARTP100030
	PPO		POS	Partners	Complete	1500/25	IPPARTC150025
	PPO		POS	Partners	Preferred	1500/25	IPPARTP150025
	PPO		POS	Partners	Basic	1500/25/40	IPPARTB15002540
	PPO		POS	Partners	Preferred	2000/25/35	IPPARTP20002535
	PPO		POS	Partners	Basic	2000/25/40	IPPARTB20002540
	PPO		POS	Partners	Complete	2500/25	IPPARTC250025
	PPO		POS	Partners	Preferred	2500/25	IPPARTP250025
	PPO		POS	Partners	Preferred	2500/30	IPPARTP250030
	PPO		POS	Partners	Preferred	3000/25/40	IPPARTP30002540
	PPO		POS	Partners	Basic	3000/25/40	IPPARTB30002540
	PPO		POS	Partners	Complete	3500/25/40	IPPARTC35002540
	PPO		POS	Partners	Complete	5000/25/40	IPPARTC50002540
	PPO		POS	Partners	Basic	5000/25/40	IPPARTB50002540

Consumers Plans (No Copays except for Preventive Care)

X	PPO	X	POS	Name	Coinsurance	Deductible	OOP Maximum	Preventive Only Copay	Form #
	PPO		POS	Consumers	Basic - 70/30	$1000/$2000	$4000/$8000	$30/$100	IPCONB1000
	PPO		POS	Consumers	Basic - 70/30	$2000/$4000	$4500/$9000	$30/$100	IPCONB2000
	PPO		POS	Consumers	Preferred - 80/20	$3000/$6000	$5000/$10,000	$25/$100	IPCONP3000
	PPO		POS	Consumers	Basic - 70/30	$3000/$6000	$5000/$10,000	$30/$100	IPCONB3000
	PPO		POS	Consumers	Preferred - 80/20	$5000/$10,000	$7500/$15,000	$25/$100	IPCONP5000

Health Savings Accounts

X	PPO	NAME	Coinsurance	Deductible	Preventive Only Copay	OOP	Form #
	PPO	Piedmont HSA	Preferred	$1500/$3000	$25/$100 20%AD	$3000/$6000	IPPIEDHSAP150025
	PPO	Piedmont HSA	Preferred	$2500/$5000	$25/$100 20%AD	$4500/$9000	IPPIEDHSAP250025
	PPO	Piedmont HSA	Preferred	$3500/$7000	$30/$100 20%AD	$5000/$10000	IPPIEDHSAP350030

Additional Riders

X	Please place an "X" by any riders you would like to include.	Rider Description	Rider Form #
	Supplemental Accident Rider	Coverage for 100% of first $750 Emergency Room AC from Accident	IPAccidental
	Vision Rider	One routine eye exam per year subject to the office visit copay	IPVision
	Supplemental Rider	Gastric Bypass, Breast Reduction, Abdominoplasty, Cochlear Implants	IPSuppRider
	Birth control / Viagra Rx Rider	Prescription Drug contraceptives and male impotence	IPRXRider
	Conversion Rider	Conversion to Non-Group coverage	IPCONVERSION

Two-Tier Rx Amendments

X	Additional Rx Deductible	Rx Amendment	Rx Code	Rx Form #
	No Rx	No Rx	No Rx	No Rx Amend
	None	$10/$20	10/20Rx	IPRX10/20
	None	$15/$30	15/30Rx	IPRX15/30
	None	$15/$40	15/40Rx	IPRX15/40
	$150	$15/$30	150Ded15/30	IPRX15015/30

Three-Tier Rx Amendments

X	Additional Rx Deductible	Rx Amendment	Rx Code	Rx Form #
	None	$10/$20/$35-20%	10203520%	IPRX10203520%
	None	$10/$30/$50	103050	IPRX103050
	None	$10/$30/$50-20%	10305020%	IPRX10305020%
	None	$10/$40/$55	104055	IPRX104055
	None	$15/$40/$55	154055	IPRX154055

Out of Pocket Amendments

X	OOP Amendment	OOP Code	Form #	X	OOP Amendment	OOP Code	Form #
	$2000/$4000	OOP 2000	IPOOP2000		$3500/$7000	OOP 3500	IPOOP3500
	$3000/$6000	OOP 3000	IPOOP3000		$4000/$8000	OOP 4000	IPOOP4000

Revised 1/23/09