

County Medical Association & Society/CMA

sponsored Medical Insurance Program

47094

For information or a quote, please complete the following information and fax it to Marsh at: **213-346-5946**

Personal Information

Member Name: _____

County Medical Association/Society: _____

Practice Name: _____

Address: _____

City: _____ State: **CA** Zip: _____

Phone: (_____) _____ Fax: (_____) _____

E-Mail Address: _____ Member's Date of Birth: ____/____/____

Coverage Requested (Choose coverage type and carriers you would like a quote from:)

Plan Type:

PPO HMO High Deductible Health Plan (for HSAs)

Small Group: (2-50 employees)

Aetna Blue Cross Blue Shield
 Health Net Kaiser United HealthCare

Individual:

Aetna Blue Cross Blue Shield

Health Savings Account Only:

I'd rather have someone call me to discuss my options.

I'm not interested in the Medical plans, but I would like to ask about other options. Please call me.

Contact Name: _____

Phone Number: (_____) _____

Best time to call: _____

Plan: _____

I already have a qualifying High Deductible Health Plan. For information, or to apply for an HSA, visit www.MarshAffinity.com.

Census Information (Required for a quote)

1	Birthdate [][]/[][]/[][][][]	Zip Code [][][][][][]	Coverage Level [][]	Gender (M/F) <input type="checkbox"/>
2	Birthdate [][]/[][]/[][][][]	Zip Code [][][][][][]	Coverage Level [][]	Gender (M/F) <input type="checkbox"/>
3	Birthdate [][]/[][]/[][][][]	Zip Code [][][][][][]	Coverage Level [][]	Gender (M/F) <input type="checkbox"/>
4	Birthdate [][]/[][]/[][][][]	Zip Code [][][][][][]	Coverage Level [][]	Gender (M/F) <input type="checkbox"/>

Fill out the birthdate, home zip code, coverage level and gender for each member/employee to be insured. For the coverage level, use the following:

EE = Employee Only
ES = Employee and Spouse
EC = Employee and Child(ren)
FA = Family

If you have additional employees, please continue on a separate sheet. Or send a census or copy of a recent invoice.

Additional Information Request (Please check below to receive information on these additional sponsored plans.)

<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Business Overhead Expense	<input type="checkbox"/> Term Life	<input type="checkbox"/> Catastrophe Major Medical
<input type="checkbox"/> Employment Practices Liability	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Group Universal Life	<input type="checkbox"/> Hospital Income Plan
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Business Owners Package	<input type="checkbox"/> Dental	<input type="checkbox"/> Accidental Death & Dismemberment
	<input type="checkbox"/> Professional Liability		