BARROOD AGENCY, INC.

Request for Group Medical Benefits Quotation

Group Name: _____ **Broker Name**:_____

Effective Date: _____ **Fax #**: _____

Current Carrier:_____ **Email:** _____

Current Plan: _____

Carriers: ☐ Aetna ☐ AmeriHealth

☐ Horizon BCBSNJ ☐ OXFORD

HSA (check choices)

Copay: ☐ N/A ☐ $20/$30 ☐ $25/$40 ☐ $30/$50 ☐ Other_____

In Network Deductible: ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ Other_____

PPO & POS Plans (check choices) ☐ Gated or ☐ Non-Gated

Copay: ☐ $15/$30 ☐ $20/$40 ☐ $25/$50 ☐ $30/$50 ☐ Other_____

Deductible: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ Other_____

Coinsurance: ☐ 100/60 ☐ 100/70 ☐ 100/ 90/ 70 ☐ 100/ 80/ 60 ☐ Other_____

HCP Rider: ☐ Yes ☐ No

Rx Card: ☐ 3 Tier ☐ 50% ☐ None

Rx after Deductible (if applicable): ☐ Yes ☐ No

HMO Plans (check choices) ☐ Gated or ☐ Non-Gated

Copay: ☐ $15/$30 ☐ $20/$40 ☐ $25/$50 ☐ $30/$50 ☐ Other_____

Deductible: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ Other_____

Coinsurance: ☐ 100% ☐ 80% ☐ 70% ☐ 50% ☐ Other_____

HCP Rider: ☐ Yes ☐ No

Rx Card: ☐ 3 Tier ☐ 50% ☐ Other_____

Rx after Deductible (if applicable): ☐ Yes ☐ No

Please note: Not all carriers offer all of the above options. Completed forms can be emailed to insurance@barrood.com. Questions regarding your quotes should be directed to 800-275-6727.