



Taranto Inc. 1750 25th Avenue, Suite 303
 Greeley, CO 80634
 800-627-7776/ 970-356-3728
 970-356-9138 fax

REQUEST FOR PSF QUOTATION

Of Eligible Employees _____ # Of Covered Employees _____

To Be Completed with Employer

Employer Name _____ Requested Effective Date _____

Address _____ Business Entity (circle one) S. Corp C. Corp
 _____ S. P. Ptr. L.L.C.

Other Locations _____

Nature of Business _____ Phone _____

Current Health Carrier _____ How Long _____

Fully Insured HMO Self-Funded Other _____

Employer Premium Contribution

Employee Life ___% Medical ___% Dental ___% Disability ___% Vision ___%
 Dependent Life ___% Medical ___% Dental ___% Disability ___% Vision ___%

Waiting Period: 1st of Month Following: Date of Hire 30 Days 60 Days
 90 Days Other _____

COBRA Participants:

Name	Qualifying Event	Employment Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has any employee or dependent experienced claims in excess of \$7,500 over the last 12 months? (List condition, outcome, approximate claim amount, if continuing claim etc.) _____

Number of employees and dependents now pregnant: _____
 Due Dates: _____

Are any employees not covered by Workers Compensation? (List employee, title, job description.)

Requested Documents From Employer:

Enclosing these items increases efficiency and accuracy of your quote.

- Copy of current billing
- Copy of previous year's rates
- Current benefits (certificate)
- Census
- 2 years (if available) complete claims information
- Plan changes (last 2 years)

MEDICAL PLAN DESIGN

Tell us what kind of plan you want quoted by completing this form.

Basic Plan Design

EPO (HMO Look-Alike)
 PPO
 Indemnity

PPO/EPO Network

Network	Territory	Network	Territory
<input type="checkbox"/> The Alliance	Colorado	<input type="checkbox"/> USA Health Net	National
<input type="checkbox"/> Mountain Medical Affiliates	Colorado	<input type="checkbox"/> Beech Street	National
<input type="checkbox"/> Sloan's Lake	Colorado	<input type="checkbox"/> Community Care Network (CCN) <small>(Only available when Mtn. Med. Affiliates is in-state provider)</small>	National
<input type="checkbox"/> Managed Care, Inc.	National	<input type="checkbox"/> PHCS <small>(Only available when The Alliance is in-state provider)</small>	National

Benefit Description	Amount
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Dr. Office Co-Pay	_____
Dr. Office Lab & X-Ray Co-Pay	_____
Other Outpatient Co-Pay	_____
<hr style="border: 0.5px solid black;"/>	
Hospital Co-Pay	_____
Emergency Room Co-Pay	_____
Other Co-Pay	_____
<hr style="border: 0.5px solid black;"/>	
Preventive Annual Maximum	_____

Benefit Description	Amount
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Out Of Pocket (including deductible)	
In Network	_____
Out Of Network	_____
<hr style="border: 0.5px solid black;"/>	
Prescription Drugs	
Generic Co-Pay	_____
Brand Name Co-Pay	_____
Mail Order Co-Pay <small>(90 day supply)</small>	_____
<hr style="border: 0.5px solid black;"/>	
Mental and Nervous	
Inpatient Days	_____
Outpatient Co-Insurance	_____
Annual Maximum	_____
<hr style="border: 0.5px solid black;"/>	
Maximum Benefit	_____

Calendar Year Deductible	
In Network	_____
Out of Network	_____
Maximum Per Family	_____
Co-Insurance	
In Network	_____
Out of Network	_____

Specific Stop-Loss:
 \$10,000
 \$15,000
 \$20,000
 Other _____

Incurred & Paid (12/12)
 12/15
 12/18
 15/12
 Other _____

Aggregate Stop-Loss to include:
 Medical
 Dental
 RX Drug

Short-term disability
 Vision
 Other _____

Incurred & Paid
 12/15
 15/12
 Other _____

Standard plan provisions will apply unless changes are specifically outlined here: _____

LIFE INSURANCE

- Minimum None As requested
- Salary Based (Multiple of Salary) Flat Amount \$ _____
- Scheduled as follows: _____

- Include AD & D

DENTAL INSURANCE

Note: Dental and Orthodontic coverage has separate deductibles unless otherwise stated. Dental coverage deductible for Preventive, Basic & Major are combined.

	Deductible	Co-Insurance
Preventive	_____	_____
Basic	_____	_____
Major	_____	_____
Annual Maximum _____		
Orthodontic	_____	_____
Orthodontic Maximum (lifetime) _____		

Standard plan provisions will apply unless changes are specifically outlined here: _____

VISION INSURANCE

	Deductible	Benefit	Coverage Period:
Exam	_____	_____	_____
Eye Glasses/Contacts	_____	_____	_____
Other _____			

SHORT TERM DISABILITY INSURANCE

- Current Plan Other _____ % of Salary Benefit Weeks _____
- Elimination period _____ Sickness _____ Accident

Other _____

Agent Name _____

Firm Name _____

Address _____

Phone _____ Fax # _____

FAX QUOTE TO
970-356-9138



EMPLOYEE CENSUS

NAME OF EMPLOYER _____

Employee Name	SEX	Age or Date Of Birth	Spouse Covered ✓	Children Covered ✓	Salary Only Needed DI or Life Quote
1.					
2.					
3.					
4.					
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