LIST OF ELIGIBLE EMPLOYEES FOR GROUP QUOTE

VIVA HEALTH

Viva Health, Inc. – Request for Group Health Plan Quote

Company Name: _____ Contact Name: _____

Address: _____ Phone #: ( ) _____

City, State, Zip: _____ Fax #: ( ) _____

Company website (if applicable): _____ E-mail: _____

Employee Name	Employee Age	Sex M/F	County of Residence	Coverage Code (See Below)	Spouse Age	Number of Dependents	*Status (See Below)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

*Please list all employees even if they are not on the company insurance plan. You can indicate that they are waiving coverage with the "W" coverage code.

How much is your total monthly health premium? _____

Current Carrier? _____

Please indicate the dollar amount (or %) of the insurance premium paid by the employer (single/family) _____

Who will make the final decision on your health care plan? _____

What effective date would you like on this quote? _____

How did you hear about Viva Health? _____

COVERAGE CODES
S = Employee Only
ES = Employee + Spouse
EC = Employee + Child
F = Family
W = Waiving

STATUS CODES
FT = Full Time
PT = Part Time
CO = Cobra

Please fax completed form to (205) 939-1748

Please call (205) 558-7599 if you have questions about completing this form.

Please make a copy of this form as needed to list all employees

*****LIST ALL FULL TIME EMPLOYEES, EVEN IF THEY ARE NOT ON THE COMPANY INSURANCE PLAN*****

www.vivahealth.com