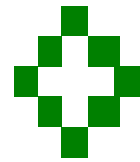


# LIST OF ELIGIBLE EMPLOYEES FOR GROUP QUOTE



# 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](http://www.vivahealth.com)**