ABC Inland Pacific

MBA Health Insurance Trust

Searching for Workers?

Better Benefits Can Help!

SCALE

Over 1,000 employers and their 22,000 employees have access to over 35 custom medical plans.

STABILITY

Since 1986, we have provided long-term rate stability, keeping our customer's costs low year after year.

SAVINGS

ABC Inland Pacific member companies save up to 10-15% on their employee benefit premiums.

SERVICE

A dedicated customer service team to serve you and your employees. We answer the phone to support you!

WHO IS THE MBA HEALTH INSURANCE TRUST?

For over 35 years, the MBA Health Insurance Trust has set the standard among association health plans with its commitment to excellence in pricing, benefit plan designs, and customer service. As a member of the Associated Builders and Contractors Inland Pacific Chapter, you can access this unique employee benefits program.

WHAT IS AN ASSOCIATION HEALTH PLAN?

Association health plans offer companies of two or more the unique opportunity to save on their health insurance premiums by leveraging the size of all members collectively for the best possible health insurance rates. This is a great way for small businesses to access the savings associated with larger group coverage.

GET A NO-OBLIGATION QUOTE FROM

ABCHEALTHTRUST.COM

Health Insurance Quote Request Form

Thank you for your interest in our program.
In order to obtain a quote, our carriers require all sections of this form be completed.

Company Information:

Company Name:	Current Insurer:
Contact Person:	Trust / Program:
Address:	Renewal Date:
City, State, Zip:	How long have you been with your Current Insurer?
Nature of Business:	Current Broker:
Phone:	Are you a member of a trade association? ☐ Yes ☐ No
Fax:	If yes, please specify :
Email:	Membership ID# Member Since:

How did you hear about the MBA Health Trust?

Cold Call Health Trust Website Referral Membership Event Advertisement Other (Please Clarify): _____

I authorize the Trust Consultants (Benefit Services Northwest) to provide our company with a proposal for the Trust.

Authorized Representative: _____ Date: _____

Please include the following information:

Census - Please include all full-time, active, eligible *employees and dependents*

Employee Name	Date of Birth	Waiving Coverage Y/N?	Zip Code	M/F	Dependent Name (Spouse/Child(ren))	Dependent Date of Birth	Zip Code

Please attach additional census, if necessary

- ☐ **Billing Statement** - Please provide your most recent billing statement.
- ☐ **Current Benefits** - Please provide information on your current employee benefits (medical, dental, vision, life, etc.)
- ☐ **Renewal Information** - If applicable, please provide your renewal rates for the upcoming plan year.
- ☐ **Transition of Care Form** - See back
- ☐ **Claims information** - If available

Please send completed forms to:

Scott Keno - Benefit Services Northwest
2107 E Huckleberry Lane, Spokane, WA 99224
Phone: (509) 863-6500 / Fax: (509) 448-4451
skeno@epkbenefits.com

We look forward to serving your company's benefit needs

Transition of Care Questionnaire

Please answer each question, to the best of your knowledge to ensure a smooth transition of care for all prospective enrollees, including: owners, employees, spouses, dependent children, domestic partners and COBRA participants. This form is elective.

1. Does your company offer wellness programs for your employees? ☐**Yes** ☐**No**
If so, please check those that apply below:

☐ Drug/alcohol screenings ☐ On-site flu shots ☐ Preventive safety classes
☐ Blood glucose screenings ☐Blood Pressure Checks ☐Smoking cessation programs
☐Other: _____

2. Are there any prospective enrollees being treated by specialty providers and/or facilities who would require coordination of care? ☐**Yes** ☐**No**

If so, please specify providers and/or facilities so we may ensure there is no disruption of care:

_____

3. Are you aware of any specialty medications utilized by prospective enrollees that would require a prior authorization? ☐**Yes** ☐**No**

If so, please specify medications so we may ensure there is no disruption of care:

_____

4. Are there any prospective enrollees on COBRA continuation coverage?

☐**Yes** ☐**No** If so, how many? _____

By completing this form I certify that the above information is correct to the best of my knowledge. This is not an application for coverage. Any group insurance coverage will not be effective until a proposal is provided, applications are completed by the group and its employees and coverage is approved by the carrier.

_____

Name of Individual Completing Form Title Signature

_____

Name of Company Date