

**Benefit Design Group Quote Order Form**     Carefirst Referral

<b>Company Name:</b> _____	
<b>Type of business:</b> _____	
<b>Street Address:</b> _____	<b>City, State, Zip</b> _____
<b>Quote Effective date:</b> _____	<b>Date needed:</b> _____
<b>Number of Full time employees:</b> _____	<b>Number of Waivers:</b> _____
<b>Agent :</b> _____	<b>Phone Number:</b> _____
<b>Fax Number:</b> _____	
<b>Current Insurance Carrier:</b> _____	<b>Renewal Date:</b> _____
<b>Medical : HMO, PPO, OPT OUT</b> _____	
<b>Coinsurance:</b> _____	
<b>Rx deductible:</b> _____	

**Census**

	Name	Age	DOB	M/F	Tier*		Name	Age	DOB	M/F	Tier*
1						18					
2						19					
3						20					
4						21					
5						22					
6						23					
7						24					
8						25					
9						26					
10						27					
11						28					
12						29					
13						29					
14						30					
15						31					
16						32					
17						33					

**Demographics**

<b>&lt;15</b> _____	<b>35-39</b> _____	<b>60-64</b> _____	<b>Individual</b> _____
<b>15-19</b> _____	<b>40-44</b> _____	<b>65-69</b> _____	<b>Parent/Child(ren)</b> _____
<b>20-24</b> _____	<b>45-49</b> _____	<b>70-74</b> _____	<b>Husband/Wife</b> _____
<b>25-29</b> _____	<b>50-54</b> _____	<b>&gt;75</b> _____	<b>Family</b> _____
<b>30-34</b> _____	<b>55-59</b> _____	<b>Medicare A&amp;B</b> _____	<b>Medicare A&amp;B</b> _____

\*Level of coverage codes:

1. Individual    2. Parent & Child(ren)    3. Husband & Wife    4. Family    5. Medicare A&B

**PLEASE FAX TO 410-494-0456**