Request for an ArmadaCare Suite Quote

Important: Download this form to your computer before you start typing. *If you don't, what you've typed will be lost when you try to save or print.*

Use this form to request a quote for Ultimate Health, Plena Health, and/or ComplaMed. See underwriting guidelines for details regarding state limitations.

Company Information

Company Name _____

Complete Company Address _____

Company Website Address _____

Industry _____ No. of Company Full-Time Employees _____

Primary Medical Plan Renewal _____ Benchmark State: _____

Effective Coverage Date for ArmadaCare Plans (1st of the month only) _____

Broker Information

Broker Name _____

Agency _____

Email _____ Phone _____

City _____ State _____

Employees to Quote

Provide the following for each participant to be included in this quote for ArmadaCare plans. Use **this Excel document** or your own with the following:

- **Name** (First and Last; same as Primary Plan)
- **Title**
- **Date of Hire** *(optional)*
- **Salary and/or Pay Grade** *(optional)*
- **Primary Medical Plan in Place at ArmadaCare Effective Date***
- **Coverage Tier** [Same as Primary Medical Plan: Employee, Employee Spouse, Employee Child(ren) or Family]
- **Number of Dependents**
- **Dental Coverage** (Y/N)
- **Vision Coverage** (Y/N)
- **Birth Date**
- **Gender** (M/F)
- **Employee Zip Code**

**Note: If employee has a Waiver or Medicare, please indicate W for Waiver Plan (Spouse's Plan or Retiree Plan) or M for Medicare and a Supplement.*

Group Primary Plans: Provide Summary of Benefits and Coverage (SBC)

Prospective/Current/Prior Plan(s):

Provide a Summary of Benefits and Coverage (SBC) *(as a PDF or JPG)* for the following plans that will be in effect with ArmadaCare plans for each participant:

- Each participant's **primary medical plan**, which must include **Rx benefit** information.*
  - If you currently have a medical reimbursement plan in place, please provide prior year's SBC.
- Each participant's **employer-sponsored dental and/or vision plans.**
  - *Note: We do NOT require primary dental or vision plans for coverage, but an SBC must be provided if you have them.*

***Waiver Plans:** Coverage can be extended to employees waiving the policyholder's primary medical plan(s) (except in ND) if they have alternate qualifying primary health coverage, provided the number of waivers does not exceed 33% of the employees enrolled. Include those employees (and dependent tiers) in the census and provide the SBC for all waiver plan(s). *Employees only on Medicare must provide evidence of enrollment in Medicare parts A, B and a supplemental plan with Part D.*

Secure submission required!

For your client s protection, please submit this form and attachments securely at https://securemail.armadacorp.net/messaging (address the email to solutions@armadacare.com). Questions? Call-1 888-852-7079.

Sirius America Insurance Company