

**INSTRUCTIONS**

For a no-obligation rate quote, complete the form below and email to [kaiser.sbu.sales@kp.org](mailto:kaiser.sbu.sales@kp.org). Please list all employees who are eligible for health care benefits.

**COMPANY INFORMATION**

Company name

Street address (no P.O. boxes)

City		State	ZIP	County
Office phone ( ) -	Ext.	Fax ( ) -	Federal tax ID (EIN) number	

Email

Number of employees who are eligible for health coverage	Number of employees on payroll with withholdings
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**BROKER INFORMATION**

Agent name			Kaiser Permanente firm ID		
Office phone ( ) -	Ext.	Fax ( ) -	Cell phone ( ) -	Email	
Firm name			License #		
Street address		City	State	ZIP	

**EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION\***

Please list all employees who are eligible for health care benefits and dependents who will also be covered. Please use additional pages as needed (you may attach an Excel spreadsheet).

First name	MI	Last name	Date of birth (mm/dd/yyyy)	Home ZIP	County	Subscriber (S) or Dependent (D)

\*All fields must be filled out completely to process this form.

**CONTACT INFORMATION**

For more information, please contact Kaiser Permanente at **800-789-4661**.