

Cal-Health-Plans Insurance Services

www.cal-health-plans.com

Broker: Bill Lorenz PH (949) 394-7676

Please print and complete this form and fax it back to: FAX (949) 203-8786

For a savings analysis, please include a copy of your current health insurance bill

Company Name: _____ Type Business or SIC code: _____

Primary Contact: _____ Daytime Ph: _____ Renewal Date: _____

Company Address: _____ City / Zip: _____

Current Insur. Comp: _____ Plan name or type (hmo, ppo etc): _____

Monthly bill for current plan: \$ _____ Company pays: Emps (%) _____ Deps (%) _____

Additional comments / needs: _____

	Employee Name	Date of Birth	Spouse (Y / N)	Num Children	Home Zip
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

Use two forms if you have more than 23 employees