Request for an Ultimate Health Quote

Use this paper form or the online ***Get a Quote*** tool at www.UltimateHealth.com.

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.*

Company Information

Company Name _____

Complete Company Address _____

Company Website Address _____

Industry _____ No. of Company Full-Time Employees _____

Primary Plan Renewal _____ Ultimate Health Effective Coverage Date (1st of the month only) _____

Broker Information

Broker Name _____

Agency _____

Email _____ Phone _____

City _____ State_____

Employees to Quote

A minimum of 3 employees need to be enrolled. Provide the following for each participant to be included in this quote. Use this Excel document or your own with the following:

- **Name** (First and Last; same as Primary Plan)
- **Primary Medical Plan in Place at Ultimate Health Effective Date***
- **Coverage Tier** [Same as Primary 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)

This form is for groups that have plans with both in-network and out-of-network coverage. If you have another coverage type, contact your Ultimate Health consultant.

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 Ultimate Health 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) if they have alternate qualifying primary health coverage, as long as the number of waivers does not exceed 33% of the employees enrolled. Those employees (and their dependent tiers) should be included in the census and SBC for all waiver plan(s) provided. *Employees who are only on Medicare will be required to 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 uhinfo@armadacare.com). Questions? Call 1-800-481-3380.