piag
Insurance Services

PIAG INSURANCE SERVICES

Medical Census Quote Form

YOU MAY SUBMIT THIS FORM ELECTRONICALLY. For your convenience, this form is fillable in Acrobat and may be submitted electronically. Save the file when completed and email to James Villanueva at jamesv@piag.org. To submit via fax, print and send to: 770.433.3066.

General Info

Company Name:_____ Address:_____ City/State/Zip:_____

Phone Number:_____ Fax Number:_____ Contact Person:_____ County:_____ Type of Business:_____

Current Carrier:_____ Effective Date:_____ # of Employees on Payroll FT:_____ PT:_____ Seasonal:_____

Employer Contributions

Employee: What amount/percent do you pay for your employee's health premium? _____

Dependent: What amount/percent do you pay for the dependent's health premium? _____

Employee Information

Employee	Sex	Age/ DOB	Status Code*	Spouse's DOB	# of Children	Child #1			Child #2			Child #3			ZIP
						Sex	Name	DOB	Sex	Name	DOB	Sex	Name	DOB	

*Enter the code to indicate the type of coverage your employees currently have: **Employee = E** **Employee & Spouse = ES** **Employee & Child(ren) = EC** **Employee & Family = EF** **Waiving Coverage = W**

Does your company offer Section 125 where employees pay their portion of the premiums with pre-tax dollars? ❑ Yes ❑ No

This service can be offered to you at no cost when signing up for our health benefit programs.

Contact **James Villanueva** with questions: **phone** 404.838.8554 | **fax** 770.433.3066 | **email** jamesv@piag.org