FULLY FUNDED HRA-HMRA® Quote Form

Date quote is needed:_______________
Proposed Plan Effective Date:_______________

Group/Business Name:____
Address:____
Broker Name:________________________Broker phone:_______________ Broker email:_____________________
HRA PEPM Commission Desired: $______

COVERAGE DETAILS

Current/Renewal Total Monthly Insurance Premiums: $________________
HDHP Total Monthly Insurance Premiums: $________________
Group Enrollment:
Singles: ___________ of those, number of employees over age 45: _____
EE+Spouse, Children or Family: _________ of those, number of employees over age 45: _____

Number of covereds likely to meet their deductible:
Single: ____ EE+Spouse, Children or Family: _____

HDHP PLAN DETAILS

Deductibles and coinsurance:
Single: $_____________ deductible, $_____________ coinsurance, at ____%
EE+Spouse, Children or Family: $_____________ deductible, $_____________ coinsurance, at ____%

Annual HSA deposits to be made by employer, if any:
Single: $_____________
EE+Spouse, Children or Family: $_____________

HRA PLAN DETAILS

Do you want us to design a HRA plan for you? ( )Yes ( )No
If yes, what is maximum the employer wants employees to pay out of pocket under this HRA plan?
Single: $_____________
EE+Spouse, Children or Family: $_____________

If no, what are the current total annual HRA claims for this group?
Single: $_____________
EE+Spouse, Children or Family: $_____________

SELF-FUNDING GOALS

Does this group want to consider self-funding in the future? If so, how much financial protection do they want to accumulate in HMRA® assets before they self-fund? $_____________________

Please email quote request to info@ahr.net or fax to 1-888-815-3921

American Health Resources, Inc.
11 N. 2nd Avenue, St. Charles, IL 60174
Toll-free: 1-800-570-3757 www.ahr.net 1-888-815-3921 (Toll-free fax)