

dba, **FIRST CAPITAL FINANCIAL SERVICES**

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Return Fax #: 916-338-3886

COMPANY INFORMATION

NAME: _____

STREET ADDRESS: _____

CITY _____ STATE: _____

Type of Ownership: Sole Proprietorship _____ Partnership: _____ Corporation: _____

Type of business/industry: _____ SIC Code: _____

Phone: (_____) _____ Fax: (_____) _____

Contact person: _____

Number of Eligible Employees: _____

Will this be the sole Carrier?: YES _____ NO _____

Current Carrier(s): _____

Active policy is: HMO _____ PPO _____ POS _____

Current Benefit Description: _____

Office Co-pay (\$ and/or %): _____

RX: NO _____ YES _____ >> Deductible _____ Co-pay Generics _____ Co-pay Brand _____

Hospitalization: _____

Please quote the following (YES or NO, circle)

HEALTH CARE: Deductible _____

HMO _____

PPO _____

POS _____

HSA _____

DENTAL/VISION: Deductible _____

HMO _____

PPO _____

Vision _____

