



Employer Enrollment - Request For Quote

Mail To: SAAGII, Inc., 3940 Freedom Circle, Santa Clara, CA 95054
 Fax at (408) 200- 7499 or call (877) 472-2444 for sales Agent

Company Name: _____

Company Address: Street _____ City _____ Zip _____

Company Phone: (____) _____ - _____ Fax No: (____) _____ - _____

Company Contact: Name _____ E-Mail _____

*Routine Care		Catastrophic Insurance			Dental			Vision		
Yes	No	Yes	No	Optional	Yes	No	Optional	Yes	No	Optional

SELECTION 1: COVERAGE NEEDED:

1. Coverage Start Date: ___ / ___ / _____
2. Number of Employees: ___ 2.1 Employees Enrolling in Plan: ___
3. Current Insurance Carrier Name: _____
4. Current Monthly Payment: \$ _____
5. Reason for Change/quote: _____

SELECTION 2: COVERED EMPLOYEES CENSUS

List the number of employees (EE) in each category who will be covered

Age (years)	EE Only	EE and Spouse	EE and Children	EE and Family
15-29				
30-39				
40-49				
50-54				
55-59				
60-64				
65+				

SELECTION 3: COVERAGE COST PAID BY

	Routine Care		Catastrophic Care		Dental		Vision	
	Membership	Cost	Monthly Premium		Monthly Premium		Monthly Premium	
Employer	Yes	No	Yes	No	Yes	No	Yes	No
Employee	No	Yes	No	Yes	Yes	No	Yes	No

*Routine Care is fee for service program. Catastrophic care provides emergency and major medical care.

Fax Completed form to (408) 200- 7499

Log on to www.saagii.com to fill and submit form on line

Call (877) 472- 2444 for More Information

BBB Member, SAAGII dba SAAGII Administrator

SAAGII Proprietary and Confidential (your information will only be used for providing quote).