



Individual & Family - Quote Request Form

Mail or Fax To: SAAGII, Inc., 3940 Freedom Circle, Santa Clara, CA 95054

Primary Member Name: _____

Mailing Address: Street _____ **City** _____ **Zip** _____

Phone: (____) _____ - _____ **Cell Number:** (____) _____ - _____

E-Mail: _____

SELECTION 1: COVERAGE NEEDED:

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

1. Coverage Start Date: ___ / ___ / ___ Number of Dependents: ___
2. Current Insurance Carrier: _____
3. Current Monthly Payment: \$ _____
4. Reason for Change/quote: _____

SELECTION 2: DEPENDENTS INFORMATION

Age	Sex	Name	Relationship	Address & Phone (If different)

*Routine Care is fee for service program. The members are solely responsible for the full fees to the service providers. A member pays SAAGII negotiated fees that is based on Medicare rates.

** Quotes for various options of deductibles and benefits from different insurance carriers will be provided.

Fax Completed Form to (408) 200-7499
Log on to www.saagii.com to submit form on line
Call (877) 472- 2444 for More Information!