



Through the



Company Name: _____

Requested Effective Date: ____/____/____

Plan Selections (Check One Plan)

HIP/NYSBG Association Plans

- 1B Prime HMO (30/50/1000/150) - with Rx (Rx Option 1)**
- 2B Select PPO (30/50/Ded&Coins/150) - with Rx**
- 3B Prime HMO (30/50/1000/150) - with Rx (Rx Option 2)**
- 4B Select PPO (30/50/Ded&Coins/150) - **NO RX****

Status	Number of Insureds	x	Rate Quote	=	Total
Employee	_____	x	\$ _____		_____
EE/Spouse	_____	x	\$ _____		_____
EE/Child	_____	x	\$ _____		_____
Family	_____	x	\$ _____		_____

Total Due: _____

Please make premium check payable to Elite Programs, Inc., the plan administrator

Broker Name _____ Date _____

Broker Signature _____ Phone _____

1-800-427-5358

Fax: 631-654-0840