Interlocal Quote Request Checklist for those with CIGNA Level Funded Medical

Group Name: _____ **Tax ID #:**_____
Address: _____ **Phone Number:** _____

Authorized Signer: _____
E-mail address:_____ **Phone Number:**_____

Administrator Contact: _____
E-mail address:_____ **Phone Number:**_____

Billing Contact: _____
E-mail address:_____ **Phone Number:**_____

Number of Pay Periods: _____

What is the date of your first payroll in Jan. 2025? _____

1. **Claims Data Form attached (Tier 1 & Tier 2)?**
    a. **Go to your Employer CIGNA portal and you can download your claims in the reports section. Once downloaded forward to benefits@winstarins.com**
2. **Current Census attached?**

    Yes No

3. **Current Plan Summaries and Rates attached?**

    Yes No

4. **Company Logo attached?**

    Yes No