Quote & See

Please fax completed request to:

(425)527-6507

Your information is protected by HIPAA guidelines and is never sold to third parties.

Company Name: _____ Contact: _____

Business Type: _____ City: _____

❑ Phone: _____ ❑ Email: _____

❑ Fax: _____ (check preferred contact method)

Please send a quote for (check all that apply): ☐ Health ☐ Dental ☐ Vision ☐ Life

If you do not have current coverage, please skip to Census Information

MEDICAL INFORMATION

Current Carrier: _____

Renewal Month: _____

Rx Copay: _____

Deductible Amount: _____

Office Visit Copay: _____

	MEDICAL	
	CURRENT RATE	RENEWAL RATE
Employee Only		
Employee & Spouse		
Employee & Children		
Employee & Family		

Total Monthly Premium: _____ Premium Includes (check all that apply) ☐ Health ☐ Life ☐ Vision

DENTAL INFORMATION

Current Carrier: _____

Renewal Month: _____

Deductible _____

Class I Benefit _____

Class II Benefit _____

Class III Benefit _____

	DENTAL	
	CURRENT RATE	RENEWAL RATE
Employee Only		
Employee & Spouse		
Employee & Children		
Employee & Family		

CENSUS INFORMATION

	Employee	Gender	Birthdate	Enroll Spouse	Spouse Birthdate	Enroll Child(ren)	Child(ren) Birthdate	Zip Code
1								
2								
3								
4								
5								
6								
7								
8								
9								

If you have any questions please call our office for more information

800-337-6177