



# 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  Health  Life  Vision  
 (check all that apply)

## 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**

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