Request for Benefits Quote

COMPANY TO BE QUOTED					
Company Name		Type of Business			SIC Code
City		State	Zip	County	
Phone	Website	WFB Membership Type		WFB Membership #	
Cooperative Affiliations		Current WFB Retro/Safety Program Member		☐ Yes ☐ No	

GROUP REPRESENTATIVE OR AGENT REQUESTING THE QUOTE					
Name			Title		
Address		City	State	Zip	County
Phone		Fax		e-mail	
Requested Effective Date		Current Agent			
# of Employees	Comments				

CURRENT MEDICAL/DENTAL COVERAGE					
Employer Contributions: _____% for Employee Coverage _____% for Dependent Coverage					
Current Medical Carrier			Name of Product	Office Visit Copay (if any)	
Medical Deductible	Coinsurance %	Renewal Date	Annual Out of Pocket Limit	Vision Coverage	
Current Dental Carrier		Dental Coinsurance %	Dental Deductible	Dental Max. Benefit / Person	

CURRENT AND RENEWAL RATES						
	Medical Coverage Plan I		Dental Coverage		Medical Coverage Plan II	
	Current Rates	Renewal Rates	Current Rates	Renewal Rates	Current Rates	Renewal Rates
Employee						
EE/Spouse						
EE/Child						
EE/Family						

Send completed Quote Request and Group Census Data to:
WFB Healthcare
1501 Fourth Avenue, Suite 2400
Seattle, WA 98101-3631
(206) 957-5157 ♦ Fax (206) 957-5145
e-mail: llarson@fbhealthcare.com

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WASHINGTON FARM BUREAU Healthcare

Group Census Form

Fax or Mail or E-mail this form along with your Request for Benefits Quote form

Company Name					
Employee Name or Identifier	**Sex M / F**	**Date of Birth**	**Enroll Spouse? Yes (Include DOB) or No**	**Enroll Children? How many?**	**Zip Code**
1.)					
2.)					
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34.)					
35.)					

SEND COMPLETED QUOTE REQUESTS TO:

WFB Healthcare
1501 Fourth Avenue, Suite 2400
Seattle, WA 98101-3631
(206) 957-5157 ♦ Fax (206) 957-5145
e-mail to WFB Quotes: rfp@fbhealthcare.com