WASHINGTON FARM BUREAU Healthcare

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
(800) 681-7177 ♦ Fax (206) 957-5145
e-mail to quotes@wfbhealthcare.com

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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SEND COMPLETED QUOTE REQUESTS TO:
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Seattle, WA 98101-3631
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e-mail to WFB Quotes: quotes@wfbhealthcare.com