

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 <input type="checkbox"/> Yes <input type="checkbox"/> 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						
<p>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</p>						

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
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SEND COMPLETED QUOTE REQUESTS TO:

WFB Healthcare
1501 Fourth Avenue, Suite 2400
Seattle, WA 98101-3631
(800) 681-7177 ♦ Fax (206) 957-5145
e-mail to WFB Quotes: quotes@wfbhealthcare.com