WASHINGTON FARM BUREAU Healthcare

Request For Quote Form

Send Completed Request For Quote Form To WFB Healthcare
quotes@wfbhealthcare.com FAX: 206-812-7556 Phone: 800-681-7177

GROUP AND BROKER INFORMATION

Broker House			
Broker Name		Current Broker?	
Phone		Fax	
Email			

Name of Group			
Address/City/State			
Zip Code		County	
Years in Business		WFB Membership Number	
Requested Eff. Date		WFB Retro Safety Program Member?	
Industry Description			
SIC		Web Site	
NAICS			

Enrollment Eligibility

1) _____ All FTE — Hours Per Week _____

2) _____ Other — Comment _____

	Name or Unique Employee Identifier	Employee Zip Code	Employee Gender	Employee DOB	Spouse or DP Y/N	Spouse or DP DOB	# of Children	Medical Plan Election	Dental Election
1									
2									
3									
4									
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MEDICAL PLAN INFORMATION

Medical Renewal Date

	Plan 1	Dual Choice/Plan 2
Current Medical Carrier		
Current Association (if Applicable		
Current Medical Plan Design		

Plan Name OR Deductible/Copay/Coinsurance/Out-Of-Pocket Maximum/Rx

Rates:	Current	Renewal	Current	Renewal	Age Rated Totals Current	Age Rated Totals Renewal
Employee Only					Plan 1	
Employee & Spouse						
Employee & Child						
Employee & Children					Plan 2	
Employee & Spouse & Child						
Employee & Spouse & Ch(ren)						
Employer Contribution:						
Employee						
Dependent						

DENTAL PLAN INFORMATION

Dental Renewal Date

	Dental
Current Dental Carrier	
Current Association (i	
Current Dental Plan Design	

Deductible/Coinsurance/Annual Maximum

Rates:	Current	Renewal
Employee Only		
Employee & Spouse		
Employee & Child		
Employee & Children		
Employee & Spouse & Child		
Employee & Spouse & Children		
Employer Contribution:		
Employee		
Dependent		

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