WBMA Health Insurance Program Quote Request

For a no obligation quote, complete the form below and fax to WBMA at 360-943-1219

In order to obtain a quote, our carriers require all sections of this form to be completed.

Group Information

Company Name____ Phone___________________________

Contact Person____ Fax_______________________________

Address____ Email_____________________________

City, State, Zip____ Please send Quote by email ☐

Current Health Insurance

☐ Group Medical ☐ Group Dental ☐ Individual Policies

Benefit Level (80/20):_________ Copay:___________ Deductible:________ Rx Benefit_______________

Current Insurer_________________________________ Renewal Date__________________________________

Please attach a summary of benefits of your current medical (and dental if applicable) plan or provide the following:

	Current Rates		**Renewal Rates**	
	Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
Employee				
Spouse				
Single Child				
Children				

What percentage do you pay toward the cost for Employees?_________% Dependents__________%
(The company must pay a minimum of 75% for employees, there is no requirement for dependent contribution.)

Employee Census

Sex M / F	Date Of Birth	Dependents Spouse	1 Child	2+ Child	Sex M / F	Date Of Birth	Dependents Spouse	1 Child	2+ Child

Please include all eligible employees - this includes all full-time, owners and active employees who have meet your company insurance benefit requirements and have met all probationary periods.