



Washington Trucking Associations

Request for Quote

Please complete all information and provide a current employee census in order to avoid a delay in receiving your quote. **Final rates will be based on actual enrollment.**
Fax completed form along with your company census to (253) 838-1793

General Information

Legal Name of Group			
Street Address	City	State	Zip Code
Additional Locations (if applicable)			
Requested Effective Date		Current Renewal Date	
Contact Person	Phone Number	Fax Number	E-mail
Nature of Business	Standard SIC Code	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership <input type="checkbox"/> Other

General Plan Information

A) How many total **ACTIVE** employees do you have? _____
 How many employees are part-time? _____
 How many employees have coverage through a company sponsored union plan? _____
 How many are participating in the insurance program(s)? _____
 How many **COBRA** employees do you currently have covered? _____

B) How much do you contribute to the cost of the insurance programs for: Employees: _____ Dependents: _____

Insurance carrier reserves the right to request documentation, including payroll records to confirm and audit the information indicated above.

Current Plan Details

Medical Carrier(s) Name			
Plan(s) Offered:	General Plan Description:		
Deductible (Individual/Family):	Annual Out-of-Pocket Maximum (Individual/Family):	Benefit Percentages:	Office Visit Copay (if applicable):
Dental Carrier Name:			
Plan Description:			

Current & Renewal Rates

	Medical Plan		Medical Plan		Dental Plan		Vision Plan	
	Current	Renewal	Current	Renewal	Current	Renewal	Current	Renewal
Employee Only								
Employee & Spouse								
Employee & Family								
Employee & Child(ren)								

General Health Risk Questionnaire (If you answer Yes to any of these questions please provide additional details)

1) Are any participants or covered dependents pregnant? If yes, how many? Due Dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Has any participant or covered dependent been treated or is expected to be treated for a serious illness or injury (e.g. cancer, AIDS, substance abuse, juvenile diabetes, cardiovascular diseases, mental illness, multiple sclerosis, rheumatoid arthritis, renal disease, pulmonary disease, etc.) been hospitalized or had surgery in the past 12 months or is expected to be hospitalized or is expecting to undergo surgery in the next 12 months? If yes, please clarify with dates, prognosis, follow-up, on-going treatments, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Do any eligible employees or dependents have chronic medical conditions (i.e. diabetes, cancer, heart problems, kidney problems, substance abuse, mental illness, etc.)	<input type="checkbox"/> <input type="checkbox"/>

Name _____ Title _____ Date _____