Health/Dental/Vision/Supplemental Quote

Date:		Coverage Type			
Company Name		*Health*	*Dental*	*Life*	*ADD*
Address				For $_____	For $_____
SIC code	*SIC code lookup*				
Company Contact					
Contact email					
Contact phone		*Website:*			

Employee's first Name	Gender	Date of Birth / Age	Coverage Code*	Spouse Birthdate	Dependent Gender/DOB	Dependent Gender/DOB	Dependent Gender/DOB
EE01							
EE02							
EE03							
EE04							
EE05							
EE06							
EE07							
EE08							
EE09							
EE10							
EE11							
EE12							
EE13							
EE14							
EE15							
EE16							

Please return to jrodriguez@texhealthct.org or fax to 512-597-0672

*Coverage Code: **EE** = Employee Only **|ESP** = Employee + Spouse **|ECH** = Employee + Child**|FAM** = Employee + Spouse + Child(ren)

Please answer these questions:-

What range of DEDUCTIBLE are you interested in?_____

Should the quote include Dependents? Y/N?_____ If YES will the company pay any *dependent* premiums?_____

Will the Company contribute more than 50% of Employee Premiums?_____

Will the Company pay any DEDUCTIBLE?_____

If covered now, who is your current Insurance carrier?_____

Any other comments :_____

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