Health Benefits Washington Corp

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"Let's Make Your Benefits Work for You!"

Please tell us about Your Company:

Company Name	**Total # Employees:** _____ **Full Time:** _____ **Part Time (less than 20 Hours)** _____
Type of Business	**Are you affiliated with Another Company? Yes ____ No ____** **Do you have Employees in Other States? Yes ____ No ____**
Address	**Quotes Requested - Check All That Apply:** _____ **Medical** _____ **Dental** _____ **Vision** _____ **Life** _____ **Disability**
City / St / Zip	**REQUESTED START MONTH/YEAR:** _____/_____ **Required # of Hours to be Eligible for Benefits? - Minimum 20** _____
Fed Tax ID (Required for Trust Quotes) **Owner** **Contact Person / Title**	**Employer Required Probationary Period:** **1st of Month after Start Date** _____ **1st of Month after 30 Days** _____ **1st of Month after 60 days** _____ **90 Days after Hire (allowed by some carriers)** _____
Email **Phone**	***Employer Contribution:*** ***Medical - Employee*** _____*% (50-100%)* ***Dependent*** *(0-100%)* _____*%* ***Dental - Employee*** _____*% (50-100%)* ***Dependent*** *(0-100%)* _____*%*

Please list ALL employees who will be covered - including their dependents, listed separately, just below Employee line.

Employee Full Name	Sex	Zip Code	Date of Birth	Spouse Name	Spouse DOB	Children(s) Name(s)	Date(s) of Birth

PLEASE ATTACH ADDITIONAL FORMS IF YOU HAVE MORE ENROLLEES, OR YOU CAN PROVIDE SPREADSHEET WITH THIS INFORMATION.