

We need all of this important information in order to generate a proposal that is accurate and specially tailored to the specific needs of your group.

Company Name _____

Nature of business _____

Street Address _____

Mailing Address _____

Phone Number _____

Fax Number _____

Email Address _____



Contact Person _____

Employer Contribution

Employee _____ %

Dependents _____ %

Monthly Health Insurance Premium Rates

Current Contract Year (Attach Copy of Current Bill & Include All Pages)

Prior Contract Year (Attach Copy of Bill)

Renewal Rates (Attach a Copy of Renewal)

Detailed Health Insurance Summary

Deductible _____

Out of pocket maximum _____

Prescription Co-pays _____

**Please attach cc of plan summary pg in benefit booklet*

Detailed Dental Insurance Summary

Maximum PCY Benefit _____

Deductible _____

Current Premium (Attach Copy of Current Bill & Include All Pages)

Renewal Premium (Attach a Copy of Renewal)

Detailed Vision Insurance Summary

Maximum PCY Benefit _____

Deductible _____

Current Premium (Attach Copy of Current Bill & Include All Pages)

Renewal Premium (Attach a Copy of Renewal)

Any other benefits or pertinent information:

Disability Income? _____

Eng Insurance & Financial Services

1520 S Pioneer Way, Suite B

Moses Lake, WA 98837

Janae Eng & Claesa View

Email deng1@ft.newyorklife.com

Tel: 509-766-7969

Fax: 509-766-7900

*Please include anyone who will be eligible within 60 days of your effective date or is on COBRA. Indicate next to their name if they are COBRA or when their enrollment date will be.

Company Name:

	Employee's Name	Gender	Zip Code	DOB	Spouse's Name	Spouse's DOB	Child(ren)'s DOB(s) & Gender
Sample:	Sam Smith	M	98837	2/3/1966	Jane Smith	9/5/1968	01/05/1998-F, 02/14/2003-M
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Company Name:

Employee's Name	Gender	Zip Code	DOB	Spouse's Name	Spouse's DOB	Child(ren)'s DOB(s) & Gender
Samuel Sam Smith	M	98837	2/8/1966	Jane Smith	9/5/1968	01/05/1998-F; 02/14/2008-M
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