TBA MEMBER INSURANCE SOLUTIONS

GROUP HEALTH INSURANCE QUOTE REQUEST FORM

Firm Name: _____

Physical Address: _____

City:_____ State:_____ Zip:_____ County: _____

Primary Contact: _____

Phone:_____ Email: _____

Total # of Employees:_____ # of Full-Time Employees:_____ # of Employees Participating: _____

Please complete each blank for all full-time employees and their participating dependents. For any full-time employees that do not wish to participate write "W" in the tier column.

Name (Last, First)	Home Zip Code	Gender (M or F)	Date of Birth (MM/DD/YYYY)	Relation (See Below)	Tier (See Below)

Relation: **Emp** = Employee **Sp** = Spouse **Ch** = Child

Tier: **EE** = Employee Only **ES** = Employee + Spouse **EC** = Employee + Child(ren) **F** = Family **W** = Waive

If additional lines are needed, please send in Excel format. Be sure to include all of the requested information listed above.

Submit Completed Forms to:

TBA Member Insurance Solutions | 6505 Lee Highway, Chattanooga, TN 37421

P: 800.347.1109 | F: 866.791.2806 | TBA@assoc-admin.com | TBAinsurance.com