# QUOTE REQUEST FORM

FINANCIAL SERVICES
INSURANCE PROGRAM

***Current Major Medical Coverage Details:***

**Company:**_____

☐ HSA ☐ Traditional
☐ PPO ☐ EPO ☐ HMO

**Monthly Premium:**_____

**Renewal Date:**_____ **Co-pay:**_____

**Deductible:**_____ **Coinsurance:**_____

**Prescription Drug Copays**_____

**Effective Date Needed:**_____

**Please Fax Your Completed Form to: (817) 569-8304**
**or E-mail it to marketing@tdamemberinsure.com**

**Questions? Information? Call (800) 677-8644**

| | | |
|---|---|---|
| **Your Name** | **Firm Name (for Small Group Quote)** | |
| **Address** | | |
| **City** | **TEXAS** | **Zip** |
| **Telephone * Business * Home** | **Fax** | **E-mail** |
| **Contact Person** | **# of Employees** | **# of Employees to be covered** |

**Complete the section below for all Individuals, Family Members or Employees to be covered. (*Please make copies or use additional paper if needed)***

| **Employee's Name Last First** | **Sex** | **Employee*** **Date of Birth** | **Spouse** **Date of Birth** | **# Children** | **Date of Birth & sex for each child** | **Home Zip Code & County** | **Occupation** |
|---|---|---|---|---|---|---|---|
| **1** | | | | | | | |
| **2** | | | | | | | |
| **3** | | | | | | | |
| **4** | | | | | | | |
| **5** | | | | | | | |

**NOTE:** The premium rates used to calculate your proposal will be the carrier's basic risk rates. Actual premiums charges may vary depending upon the existence of certain factors that deviate from standard cost of services. The factors, together called "the risk adjustment factor", include but are not limited to, medical history, type of industry, and turnover. * Primary insured if quoting Individual Major Medical Insurance ☐