QUOTE REQUEST FORM

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 Initial Last Name	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 ☐