



COMPANY TO BE QUOTED						
Company Name			Address			
City			State	Zip	County	
Phone	# of Locations		WRA or WSH&LA Member?		Out of State Employees?	
SIC Code						
GROUP REPRESENTATIVE OR AGENT REQUESTING THE QUOTE (Agents not directly requesting this quote will not be authorized to assist or broker this account the first 12 months)						
Name			Title			
Phone		Fax		e-mail		
Requested Effective Date		Employer Contribution: EE _____% Dep _____%				
CURRENT MEDICAL/DENTAL COVERAGE (or include benefit summary)						
Current Medical Carrier			Name of Product		Office Visit Copay (if any)	
Medical Deductible	Coinsurance %	Prescription Copays	Annual out of pocket limit		Vision Coverage	
Current Dental Carrier		Dental Coinsurance %	Dental Deductible		Dental Max. . Benefit/Person	
CURRENT AND RENEWAL RATES						
	Medical Coverage Plan I		Dental Coverage		Medical Coverage Plan II	
	Current Rates	Renewal Rates	Current Rates	Renewal Rates	Current Rates	Renewal Rates
Employee						
Emp./Spouse						
Emp./Child						
Emp./Family						

SEND COMPLETED QUOTE REQUESTS TO:
H.I.H.I.T.
209 Main Avenue South Suite 100
North Bend, WA 98045
(425) 557-9203 ♦ Fax (425) 557-9206
 e-mail: pam@hihittrust.com