FINANCIAL SERVICES
INSURANCE PROGRAM

Please Fax Your Completed Form to: (817) 569-8304 or E-mail it to marketing@tdamemberinsure.com Questions? Information? Call (800) 677-8644

QUOTE REQUEST FORM

Please quote the following coverage:

- ❑ Individual Major Medical
  With Full Maternity Without Maternity
- ❑ HSA with qualified High Deductible Health Plan
- ❑ Small Employer Major Medical
- ❑ Long Term Care Insurance
- ❑ Disability Insurance
- ❑ Term Life Insurance

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

Current Major Medical Coverage Details:

Company:_____
Monthly Premium:_____
Renewal Date:_____ **Co-pay:**_____
Deductible:_____ **Coinsurance:**_____
Prescription Drug Copays_____
Effective Date Needed:_____
Known health conditions:_____
_____
_____

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