TakeCare

GROUP INFORMATION:

Group Name:
Mailing Address: Phone:
Physical Address: Fax:

Title:
Contact Name:
Email:

Nature of Business: Years in Business:
Type of Ownership: TIN or EIN:
Type of Business: Employees In:

ENROLLMENT INFORMATION:

	FULL-TIME	PART-TIME	RETIRED	COBRA	OTHERS
Number of Employees:					
Eligible Employees:					
Currently Enrolled:					

Filed or Currently under Chapter 11?
Wait Period:

WORKERS' COMPENSATION INFORMATION:

Name:
Address:

BROKER INFORMATION:

Broker Name:
Address:
Broker's Agreement:
Does TC pay the broker any commission?
If "YES", Specify:

CONTRIBUTION POLICY: (Dollars or Percent) Must be at least 50% of Single Rate

Medical Contribution Level:
Dental Contribution Level:

REQUESTED PLAN INFORMATION:

Carriers (past 5 years):
Renewal Date:
Rate Tier:
Current Plan:
Contract Duration:

Requested Plans:

Plan Description 1:

TakeCare

Riders:
Eligible Dependents:
Plan Description 2:

Riders:
Eligible Dependents:
Plan Description 3:

Riders:
Eligible Dependents:
Plan Description 4:

Riders:
Eligible Dependents:
Plan Description 5:

Riders:
Eligible Dependents:

Special Arrangements:

NOTE: I have reviewed and certified all these information to be correct and accurate.

Account Executive:

Signature: Date: