OMB Health Choice

Request for Health Insurance Proposal

FAX THIS FORM TO: (360) 754-7448

Business Name _____ Current Health Plan _____

Address _____ Renewal Date _____

Contact Person _____ Title _____ Deductible _____ Office Visit CoPay _____

Phone # _____ Email _____ Rx Coverage_____ Vision? Y N Dental? Y N

	Employee Name	Employee's Birthdate	Gender M/F	Full-Time	Part-Time	Waiving	Spouse's Birthday (if covered)	Spouse's Gender	# of Children (if covered)	Children's Birthday(s)	Children's Gender
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