Please return form to:
info@probenefitswa.com or
jodi@probenefitswa.com
800.808.9020 (fax)
425.643.3350 (ph)

PRO BENEFITS OF WA

GROUP INFORMATION

BUSINESS NAME		**EMAIL**	
CONTACT NAME		**PHONE**	
ADDRESS			
NATURE OF BUSINESS		**TOTAL # EMPLOYEES**	

CURRENT GROUP COVERAGE - *if applicable*

CURRENT GROUP MEDICAL RENEWAL MONTH

CURRENT CARRIERS ***Medical*** ***Dental*** ***Vision*** ***Other***

EMPLOYEE/DEPENDENT CENSUS

Please include a second page if needed

Required for Disability Quotes ONLY.

For groups of 1-2: New rules apply, which can affect eligibility
Additional fees apply

#	DOB	ZIP CODE	GENDER	SPOUSE DOB	# CHILDREN	CHILD 1 DOB	CHILD 2 DOB	CHILD 3 DOB	EMPLOYEE STATUS (Active, Waive, Etc.)	*SALARY/ ANNUAL $	*JOB TITLE
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