



GROUP HEALTH INSURANCE QUOTE REQUEST FORM

Practice Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Primary Contact: _____

Phone: _____ Email: _____

Total # of Employees: _____ # of Full-Time Employees: _____ # of Employees Participating: _____

Please complete each blank for all full-time employees and their participating dependents. For any full-time employees that do not wish to participate write "W" in the tier column.

Name (Last, First)	Home Zip Code	Gender (M or F)	Date of Birth (MM/DD/YYYY)	Relation (See Below)	Tier (See Below)

Relation: Emp = Employee Sp = Spouse Ch = Child

Tier: EE = Employee Only ES = Employee + Spouse EC = Employee + Child(ren) F = Family W = Waive

If additional lines are needed, please send in Excel format. Be sure to include all of the requested information listed above.

Submit Completed Forms to:

TDA Insurance Agency, Inc. | 6505 Lee Highway, Chattanooga, TN 37421

P: 800.347.1109 | F: 866.791.2806 | tda@assoc-admin.com | tdainsurance.com