



ASA
Agri-Services Agency

Farmers' Health Cooperative
Request For Quote Information Form



Employer Name:

Address:

Contact Person:

City:

State:

Zip:

Type of Business:

Phone:

Fax:

County:

Requested Effective Date:

Email Address:

Current Carrier:

Current Deductible:

Current Plan Type: HMO PPO Traditional

Desired Coverage: \$300 Ded PPO \$500 Ded PPO \$1,000 Ded PPO \$2,500 Ded PPO \$2,500 Ded HSA \$5,000 Ded HSA

Eligible Employees = working (check one): 30 hours per week 20 hours per week Other: _____ Total number of employees: _____

	Name of ALL FULL TIME eligible employees	Date of Hire	Date of Birth	Gender	Number of Children	Coverage Level*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

* COVERAGE LEVEL: E = Employee only ES=Employee/Spouse EC = Employee/Child F = Family W = Waiving (provide reason)