

# INSURANCE CENTER

# QUOTE REQUEST

OBTAIN QUOTES FROM SOME OF THE COUNTRIES TOP HEALTH CARRIERS  
BY COMPLETING THIS FORM AND FAXING TO (361) 854-6245

Today's Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Type of Business \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_

Fax No.: \_\_\_\_\_

Current Health Carrier: \_\_\_\_\_

Renewal Date: \_\_\_\_\_ Monthly Premium: \_\_\_\_\_

### Coverage Requested

Employ	Sex	Age	Emp Only	Emp/Spouse	Emp/Children	Family
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

Also, please provide me information on these other employee benefit plan options

- Group/Ind Health  Group Disability  Group Life and AD&D  Dental  
 Group Long Term Care  401(K), Pension Plans  Section 125 (Cafeteria Plan)

Please fax this completed form to: (361) 854-6245

If you have any questions about this form or product, please call:

**GAE CALLAWAY**

**361-855-3261 or (800) 880-3261**

Check here and fax this back to us if you want your number removed from our fax list.

Fax No. \_\_\_\_\_

