BNCW Health Choice

Request for Health Insurance Proposal

FAX THIS FORM TO: (509) 665-6669

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	Birthdate	Full-Time	Part-Time	Waiving Coverage	Spouse Name (if covered)	Spouse's Age	# of Children (if covered)
			----------	*check one*	----------			
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