

TRAW Health Insurance Program Quote Request

member of the Towing & Recovery Association and would like to receive information on the available Health Insurance Plans, complete these forms

Michael Carney
Michael T Carney Insurance Agency
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In order to obtain a quote, our carriers require all sections of this form to be completed.

Group Information	Company Name:	Phone:
	Contact Person:	Fax:
	Address:	Email:
	City, State, Zip:	Date Business Started:
	Nature of Business:	SIC Code:
	Are you a member of the Towing & Recovery Association? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide: _____ Membership ID#: _____ Member Since: _____		
I authorize the TRA/BIAW Trust Consultants (Capital Benefit Services, Inc.) to provide our company with a proposal for the BIAW Trust.		
Authorized Representative: _____		Date: _____

Current Health Insurance	<input type="checkbox"/> Group Medical <input type="checkbox"/> Group Dental <input type="checkbox"/> Individual Policies <input type="checkbox"/> None				
	CURRENT INSURER _____ TRUST / PROGRAM _____		RENEWAL DATE _____		
	Please attach a summary of benefits of your current medical (and dental if applicable) plan or provide the following:				
	Benefit Level (80/20): _____		Copay: _____ Deductible: _____ Rx Benefit: _____		
		<u>CURRENT RATES</u>		<u>RENEWAL RATES</u>	
		Medical / Rx Drugs	Dental	Medical / Rx Drugs	Dental
<i>Employee</i>					
<i>Spouse</i>					
<i>Single Child</i>					
<i>Children</i>					
What percentage do you pay toward the cost for Employees? _____ % Dependents? _____ % (The company must pay a minimum of 75% for employees, there is no requirement for dependent(s) contribution).					

Employee Census	Please include all Eligible Employees; Eligible Employees include all full-time, active employees and owners who have satisfied your company's probationary period for insurance coverage. Please include additional census if your company has 21 or more employees.									
	SEX M/F	DATE of BIRTH	DEPENDENTS			SEX M/F	DATE of BIRTH	DEPENDENTS		
			Spouse	1CH	2 + CH			SP	1CH	2 + CH