TWFG INSURANCE SERVICES

Group Benefits Quote Request Form

AGENT: _____ _____ _____@TWFG.net
(name) (phone) (email)

CLIENT: _____ **Zip Code** _____ **Effective Date** _____

Census

List all eligible full-time employees, including terminated on continuation. DO NOT ask you employees about their health conditions.

Coverage Tiers Defined:

Employee Only……**EO**
Employee + Spouse.....……**ES**
Employee + Child(ren)……**EC**
Employee + Family……..**EF**

WC Waiving with Other Insurance

D Declining without any Other Insurance

#	Home Zip Code	Gender	DOB	Coverage Tier	# of Children	Known Health Conditions
1				select one		
2				select one		
3				select one		
4				select one		
5				select one		
6				select one		
7				select one		
8				select one		
9				select one		
10				select one		
11				select one		
12				select one		
13				select one		
14				select one		
15				select one		
16				select one		
17				select one		
18				select one		
19				select one		
20				select one		

Please provide a copy of the most current bill for each employee benefit product you currently provide your employees.

SUBMIT