GROUP HEALTH PROPOSAL REQUEST FORM

Practice Name: ____

Physical Address: ____

City:_______________________________ State:________ Zip:__________ County: __________________________

Primary Contact: ____

Phone:____ Fax: ______________________________________

Email: ____

Type of Business:_____________________________________ Group Tax ID: _______________________________

Total # of Employees:___________ # of Full Time Employees:___________ # of Employees Participating:__________

Please complete each blank for all full time employees and their participating dependents. For any full time employees that do not wish to participate write "W" in the tier column.

Last Name	First Name	Home Zip Code	Gender (M or F)	Date of Birth (MM/DD/YYYY)	Tobacco (Y or N)	Relation (See Below)	Tier (See Below)

Relation: **Emp** = Employee **Sp** = Spouse **Ch** = Child

Tier: **EE** = Employee Only **ES** = Employee + Spouse **EC** = Employee + Child(ren) **F** = Family **W** = Waive

If additional lines are needed, please send in Excel format. Be sure to include all of the requested information listed above.

Submit Completed Forms to:

TMA Insurance | 6505 Lee Highway, Chattanooga, TN 37421

P: 800.347.1109 | F: 866.791.2806 | TMA@assoc-admin.com | TMAinsurance.com