HOSPITALITY HEALTH INSURANCE
FORMERLY H.I.H.I.T.

Fax or e-mail this completed form to the address listed below.

COMPANY TO BE QUOTED					
Company Name			Type of Business		
City			State	Zip	County
Phone	# of Locations		Member of WLA or WRA?		Out of State Employees?
SIC Code					

GROUP REPRESENTATIVE OR AGENT REQUESTING THE QUOTE
(Agents not directly requesting this quote will not be authorized to assist or broker the account for the first 12 months)

Name	Title	
Phone	Fax	e-mail
Requested Effective Date	Employer Contribution: EE _____%	Dep _____%

CURRENT MEDICAL/DENTAL COVERAGE (or include benefit summary)

Current Medical Carrier			How Many Years with Current Medical Carrier?	Office Visit Copay (if any)
Medical Deductible	Coinsurance %	Prescription Benefit	Annual out of pocket limit	Vision Coverage
Current Dental Carrier		Dental Coinsurance %	Dental Deductible	Dental Max. . Benefit/Person

CURRENT AND RENEWAL RATES

	Medical Coverage Plan I		Dental Coverage		Medical Coverage Plan II	
	Current Rates	Renewal Rates	Current Rates	Renewal Rates	Current Rates	Renewal Rates
Employee						
Emp./Spouse						
Emp./Child						
Emp./Family						

SEND COMPLETED QUOTE REQUESTS TO:
H.I.H.I.T.
209 Main Avenue South Suite 100
North Bend, WA 98045
(877) 892-9203 ♦ Fax (877)892-9203
e-mail: quotes@hihittrust.com