

Walker Insurance Agency
(360)658-9800 FAX (425)953-4034
1029 Cedar Avenue, Marysville, WA 98270

Group Medical / Dental / Vision Plan

Company Name _____

Primary Contact Person _____

Phone _____ Fax _____

Employee Information

Dependants Covered

1) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
2) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
3) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
4) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
5) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
6) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
7) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children
8) Name: _____	Age _____	<input type="checkbox"/> Spouse
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 1 Child
Birthdate _____	<input type="checkbox"/> Medicare (65+)	<input type="checkbox"/> 2+ Children

Please fill out the information for each employee or member of the organization. If dependant coverage is selected, indicate the dependants in each household not covered by a separate plan at the time of enrollment.