FormFire Employer Form

Employer Name: _____

Tax ID: _____ SIC Code/Industry: _____

Group Contact Name: _____ Group Contact Phone: _____

Group Contact Email: _____

Address: _____

City, State, Zip: _____

Coverage Selection: ☐ Medical ☐ Dental ☐ Vision ☐ Life

Health Insurance Deductible: $_____ Life Insurance Amount: $_____

Number of Employees: Full-time: _____ Number insured: _____ Part-time: _____

Full-Time Employees

#	Name	Date of Birth
1		
2		
3		
4		
5		
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