



Chamber Advantage

“Helping Meet Your Insurance Needs”

Insurance Program Questionnaire

Member Name: _____

Person to Contact: _____

Address (Street, City): _____

Phone: _____ Fax: _____

E-Mail: _____

Number of Employees: _____ Number of years in business: _____

What type of Business do you have? _____

I am interested in the following programs:

- | | |
|---|--|
| <input type="checkbox"/> Group Major Medical Health | <input type="checkbox"/> Group Dental |
| <input type="checkbox"/> Group Disability | <input type="checkbox"/> Group Life |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> General Liability |
| <input type="checkbox"/> Property (Building & Contents) | <input type="checkbox"/> Business Auto |
| <input type="checkbox"/> Professional Liability | <input type="checkbox"/> Individual Life |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Section 125 |

Please **Fax** this Questionnaire to Us! **Fax Number : 762-2309**

Call us if you have questions - 769-2965. Thank you. The Avara Moorer Group