Quotation Request Form
Migrant Workers Insurance Program (MWIP™)

Name of Employer:		**EMAIL or FAX to**	**Date:**
Address of Employer:		**Delta Pacific Benefit Brokers Ltd**	
Phone Number:		**email:** deltap@delsure.com	
Cell Phone:		**Fax:** 604 590 0617	
FAX:		**Telephone:** 604 590 0680	
EMAIL:		Attn: Andy or Kim	
Contact Person:		***Please phone to confirm receipt***	

	Name of Employee	Country of Residence	Sex M or F	Date of Birth D/M/Y	Arrival Date D/M/Y	Contract Ends D/M/Y
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