



OREGON SMALL GROUP HEALTH INSURANCE QUOTE REQUEST

Employer information, current benefits and requested plan design

1. BUSINESS & CONTACT INFORMATION

Legal business name

DBA / trade name (if any)

Physical business address

City

County

ZIP

Primary contact

Title

Phone

Email

Type of business / industry

NAICS code (if known)

Federal EIN (optional for quote)

Requested effective date

Full-time EEs

Part-time EEs

Benefit-eligible EEs

Expected to enroll

Current medical carrier (if any)

2. ELIGIBILITY & EMPLOYER CONTRIBUTION

Minimum hours / week

Waiting / probationary period

Employer contribution - employee (\$ or %)

Employer contribution - dependents (\$ or %)

3. CURRENT BENEFIT DESIGN & PRODUCTS

Current carrier and medical plan name(s)

Renewal date

Renewal change % (if known)

Current design - deductible, OOP max, coinsurance, office / Rx copays

Current products:

☐ Medical

☐ Dental

☐ Vision

☐ Life

☐ STD

☐ LTD

☐ SBC attached

Current EE contribution

Current dependent contribution

Approx. employer monthly cost (optional)

4. DESIRED BENEFITS & PRIORITIES

Quote products:

☐ Medical

☐ Dental

☐ Vision

☐ Life

☐ STD

☐ LTD

Target employer contribution / budget

Medical priorities:

☐ HSA / HDHP

☐ Lower premium

☐ Lower deductible

☐ Broad network

☐ Multiple plans

Must-have doctors, hospitals, pharmacies or networks

Other goals, preferences, concerns or notes

For preliminary quoting only - not an application for coverage. Do not include Social Security numbers or medical history.

Carrier eligibility, participation and documentation requirements may vary; additional information may be requested.



GROUP CENSUS

Oregon Small Group Health Insurance Quote

(541) 314-9075

List every benefit-eligible employee, including employees waiving medical coverage, and all dependents to be quoted.

Use the same Family ID for an employee and dependents. Relationship codes: EE = employee, SP = spouse, DP = domestic partner, CH = child. Gender: M/F/X. Tobacco: Y/N for age 18+. For Med/Dent/Vision enter Y or N. If medical is waived, use waiver code: G = other group coverage, M = Medicare/Medicaid, I = individual coverage, O = other.

Family ID	Employee / Dependent Name or ID	Rel.	Gender	DOB	Home ZIP	Tobacco 18+	Med	Dent	Vision	Waiver Code	Notes

Completed by

Date

Total eligible EEs

EEs enrolling medical

EEs waiving medical

Census page ____ of ____