



WESTERN GROCERS EMPLOYEE BENEFITS TRUST

Health Insurance and Benefit Options Exclusively for Food Industry Employers

REQUEST FOR QUOTE

As simple as 1 - 2 - 3

TELL US ABOUT YOU				
1	Business Name	SIC Code	Contact Name	
	Physical Address	City	State	Zip
	Mailing Address / <input type="checkbox"/> same	City	State	Zip
	Business Phone	Fax	Email	

BENEFIT OPTIONS WOULD YOU LIKE QUOTED	
2	Select BENEFIT OPTIONS you would like quoted (see benefit descriptions)
	<input type="checkbox"/> BASIC ~ \$30 office visit co-pay Use doctors from network (PPO) \$1500/\$3000 Deductible • Plan pays 80% in network
	<input type="checkbox"/> PRIMARY ~ \$30 office visit co-pay Use doctors from network (PPO) \$1000/\$2000 Deductible • Plan pays 80% in network
	<input type="checkbox"/> TRADITIONAL ~ \$25 office visit co-pay Use doctors from network (PPO) \$750/\$1500 Deductible • Plan pays 80% in network
	<input type="checkbox"/> STANDARD ~ \$20 office visit co-pay Use doctors from network (PPO) \$500/\$1000 Deductible • Plan pays 80%
	<input type="checkbox"/> PREMIER ~ \$20 office visit co-pay Use doctors from network (PPO) \$250/\$500 Deductible • Plan pays 80%
	Select PLAN OPTIONS you would like quoted
	<input type="checkbox"/> INCREASE LIFETIME MAXIMUM MEDICAL BENEFIT TO \$2 MILLION
	<input type="checkbox"/> DENTAL INSURANCE ~ 3 Benefit options for annual maximums
	<input type="checkbox"/> 125 PLAN ~ Flexible Benefits. Lowers payroll tax and helps employees reduce their own cost
<input type="checkbox"/> ON-JOB COVERAGE FOR OWNERS ~ Replaces work comp for owners	

ABOUT YOUR CURRENT BENEFITS				
	Total Employees in Oregon	Total Employees in Washington	Total Number of Employees Eligible for Benefits	Waiting Period for Benefits
				% of Premium Employer Pays for Employees _____% Dependents _____%
3	<input checked="" type="checkbox"/> Please provide Employee Census Data per the form on page 2			
	<input checked="" type="checkbox"/> Name of your current Health Insurer? _____ Renewal Date: ____ / ____ / _____			

TO RECEIVE YOUR HEALTH INSURANCE QUOTE, SIMPLY FAX or MAIL THIS FORM TO:

Western Benefits Inc. Administrator
14835 S.E. 82nd Drive • Clackamas, OR 97015
Fax Number: 503.968.2817



WESTERN GROCERS EMPLOYEE BENEFITS TRUST

EMPLOYEE CENSUS SHEET

Employer Name: _____

NOTE: You may send this information from your own form if complete

EMPLOYEE NAME	GENDER M / F	BIRTH DATE	HOURS WORKED PER WEEK	RESIDENCE ZIP CODE	EMPLOYEE ON PLAN Y / N	SPOUSE ON PLAN Y / N	NUMBER OF CHILDREN ON PLAN
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
23.							
25.							

* See page two for additional employees if necessary

To the best of my knowledge, I certify that all of the information contained above is correct. I understand that the final rates are determined on actual enrollment.

Your signature: _____ Position: _____ Date: ___/___/___

FAX TO : Western Benefits Inc. Administrator / **Fax Number: 503.968.2817**



WESTERN GROCERS EMPLOYEE BENEFITS TRUST

EMPLOYEE CENSUS SHEET

PAGE 2

Employer Name: _____

EMPLOYEE NAME	GENDER M / F	BIRTH DATE	HOURS WORKED PER WEEK	RESIDENCE ZIP CODE	EMPLOYEE ON PLAN Y / N	IS SPOUSE ON PLAN Y / N	NUMBER OF CHILDREN ON PLAN
26.							
27.							
28.							
29.							
30.							
31.							
32.							
33.							
34.							
35.							
36.							
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47.							
48.							
49.							
50.							

Disclosure Notice to Oregon Employers: *If you have more than 50 employees, you may request a health insurance quote as a large group. If your group has more than 50 employees, but only 2-50 eligible employees and limits coverage under the health insurance plan to all eligible employees, or if the group has 26-50 eligible employees and limits coverage to a class of eligible employees, you may request a quote as a small employer. Health insurance carriers are required to provide a small employer quote to Oregon small employers upon request and must provide small employer coverage if the employer accepts that quote.*

I am requesting a small employer quote for my group health plan _____ (initials)

To the best of my knowledge, I certify that all of the information contained above is correct. I understand that the final rates are determined on actual enrollment.

Your signature: _____ Position: _____ Date: ___ / ___ / ___