WESTERN GROCERS EMPLOYEE BENEFITS TRUST

Health Insurance and Benefit Options Exclusively for Food & Hardware Industry Employers

REQUEST FOR QUOTE

As simple as 1 – 2 - 3

TELL US ABOUT YOU

❶

Business Name - SIC Code		Contact Name		
Physical Address		City	State	Zip
Mailing Address / ☐ same		City	State	Zip
Business Phone	Fax	Email		

BENEFIT OPTIONS WOULD YOU LIKE TO CONSIDER

❷

Select BENEFIT OPTIONS of interest (see benefit descriptions, all plans use Provider Networks)

- ☐ **FOUNDATION** ~ $30 office visit co-pay — $3000 / $6000 Deductible • Plan pays 80% in network
- ☐ **BASIC** ~ $30 office visit co-pay — $1500 / $3000 Deductible • Plan pays 80% in network
- ☐ **PRIMARY** ~ $30 office visit co-pay — $1000 / $2000 Deductible • Plan pays 80% in network
- ☐ **TRADITIONAL** ~ $25 office visit co-pay — $750 / $1500 Deductible • Plan pays 80% in network
- ☐ **STANDARD** ~ $20 office visit co-pay — $500 / $1000 Deductible • Plan pays 80%
- ☐ **PREMIER** ~ $20 office visit co-pay — $250 / $500 Deductible • Plan pays 80%
- ☐ **LOWER COST PLANS THAT PAY A 70/30 BENEFIT LEVEL**
- ☐ **INCREASED BENEFITS FOR ☐ LIFE INSURANCE - or - ☐ SHORT TERM DISABILITY**
- ☐ **DENTAL INSURANCE ~** 3 Benefit options for annual maximums
- ☐ **125 PLAN ~ Flexible Benefits.** Lowers payroll tax and helps employees reduce their own cost

ABOUT YOUR CURRENT BENEFITS

❸

TOTAL EMPLOYEES Oregon	Washington	Alaska	Total Number of Employees Eligible for Benefits	Number of Hours required to be Eligible for Benefits	Waiting Period for Benefits	% of Premium Employer Pays for
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✓ **Please provide Employee Census Data per the form on page 2**

✓ **Name of your current Health Insurer?** **Renewal Date:** / /

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

Cypress Benefit Administrators
PO BOX 22166 ◆ Portland, OR 97269 ◆ P: 800.777.3603 ◆ **F: 503.968.2817**

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EMPLOYEE CENSUS SHEET

Employer Name: ______________________________

NOTE: List all employees eligible for benefits. 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.							
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17.							
18.							
19.							
20.							
21.							
22.							
23.							
23.							
25.							

* Copy 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 GROCERS TRUST - 503.968.2817