WESTERN GROCERS EMPLOYEE BENEFITS TRUST

Health Insurance Programs Employers Can Trust

Dear eligible Employer,

Would you be interested in a Health Insurance program that was built just for businesses like yours? Please consider joining the many employers who participate in Western Grocers Trust in Washington, Oregon and Idaho. You are eligible to join an exclusive program created and maintained for Retail Grocery and Hardware Employers. Each year of our over 40 years of service, 95% of our members choose to renew to use the Trust's programs.

As an eligible business, we invite you to send us your group census information so we can prepare plan options for you with no obligation. (see back)

Employers often report that their health insurance costs continue to rise while service declines. If this is an issue in your business, we encourage you to consider our solutions. Business owners appreciate our many options designed to meet the needs of their employees and their budgets.

We focus on key principles to provide our eligible participants a quality option in the insurance marketplace.

- Superior service delivered by real people, not automated voices
- Speedy and accurate claims processing
- A variety of coverage options to fit your unique needs
- An Employee Assistance Program
- A comprehensive member services website.
- Service staff committed to your industry for over 30 years
- A strong Provider Network
- Competitive Options to meet your objectives

It's time to see cost saving options for 2022! We hope we might have an opportunity to serve your needs. Please feel free to call us directly for more information, or simply go to our website to request a proposal.

Contact Tom Newton at 503.718.8236 or tomn@westerngrocerstrust.com

Visit www.WesternGrocersTrust.com to learn more about the Trust
(use employer access code: wgt14)

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EMPLOYEE CENSUS FORM

PLEASE COMPLETE AND RETURN BY MAIL, FAX OR EMAIL

BUSINESS NAME_____ CONTACT PERSON_____ DATE_____/_____/_____

MAILING ADDRESS_____ CITY_____ ST_____ ZIP_____ COUNTY_____

PHONE_____ FAX_____ EMAIL _____

Please list all eligible employees. For those enrolling, identify any dependents to be included. For eligible employees not enrolling, identify why in the waiver reason column.

Dependent Relationship:
C = Child
S = Spouse
D = Domestic Partner

Waiver Codes:
D = Declined
O = Other coverage
M = Medicare/Medicaid

EMPLOYEE NAME | If dependents are to be covered, list name(s) after employee and include Birth Date and Relationship	BIRTH DATE xx / xx / xxxx	DEPENDENT RELATIONSHIP C / S / D	HOURS WORKED PER WEEK	EMPLOYEE ENROLLING Y or N	If NO – Waiver Reason Code D / O / M

Note: Copy this page to list additional employees or provide us the information on your own form if you prefer.

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