



Pacific Benefit Planners Employee Benefits Specialists

Eugene Office
800 Willamette St. #620
Eugene, OR 97401
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Portland, Oregon
One Main Place
101 SW Main Street Suite 1905
Portland, OR 97204
Phone: 503-223-3638

Please fill out, print and return by fax or mail to Pacific Benefit Planners.

Date: _____ **Tax ID #:** _____ **SIC Code#:** _____
Business Name: _____ **Db:** _____
Address: _____
Phone: _____ **Fax:** _____
Nature of Business: _____ **How Long in Business:** _____
Contact: _____ **Contact:** _____

Employer Contribution-Medical: Employee: _____ Dependent: _____
Employer Contribution-Dental: Employee: _____ Dependent: _____
Probationary Period: First of the month following: ___30___60___90 days
Requirement for Coverage: ___ hours per week to be eligible (must be at least 17.5 hrs)
Number of Employees (include all full time, part time, new hires and those on cobra): ___
Number of Eligible Employees: _____
Number of employees on Cobra or Continuation _____
Number of Employees Out of State: _____
If there are out of state employees, list zip codes: _____

Health Insurance Carrier: _____ **Renewal Date:** _____
Plan Design: _____
Current Premium: Employee _____ Employee/Spouse _____ Family _____
Employee/Child(ren) _____
Renewal Premium: Employee _____ Employee/Spouse _____ Family _____
Employee/Child(ren) _____

Dental Insurance Carrier: _____ **Renewal Date:** _____
Plan Design: _____
Current Premium: Employee _____ Employee/Spouse _____ Family _____
Employee/Child(ren) _____ **Renewal Premium:** Employee _____ Employee/Spouse _____
Family _____ Employee/Child(ren) _____

Group Life: No Yes (if yes: Carrier: _____) Plan Design _____
Current Premium: _____ Renewal Premium: _____

Long Term Disability: No Yes (if yes: Carrier: _____) Plan Design _____
Current Premium: _____ Renewal Premium: _____

Short Term Disability: No Yes (if yes: Carrier: _____) Plan Design _____
Current Premium: _____ Renewal Premium: _____

Retirement Plan: No Yes (if yes: Carrier: _____) Plan Design _____

Flexible Spending Account 125(k): No Yes (if yes: Carrier: _____)

Employee Assistance Program: No Yes (if yes: Carrier: _____)

Supplementary Insurance: No Yes (if yes: Carrier: _____)

Notes: _____

