Pacific Benefit Planners

Employee Benefits Specialists

Eugene Office
800 Willamette, Suite 620
Eugene, OR 97401
Phone: 541-341-3478
Toll-free: 1-866-341-3478
FAX: 541-341-1354

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:_________________________________ **Dba:**__________________________

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:____
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