



Group Quote Request Form

Requested Effective Date: _____ Producer: _____

Company Name: _____
 Company Address: _____ City/State: _____ ZIP: _____
 Company Contact: _____ Contact Phone: _____ Industry: _____
 Renewal Date: _____ Employer Contribution for Employees: _____ Contribution for Dependents: _____
 Total # of Employees: _____ Waiving: _____ Ineligible: _____
 Current Carrier: _____ Do 51% or more of your employees work in Oregon? Y N
 Eligibility Hours per Week Required for Coverage: _____ Probationary Period: _____
 Current Plan Benefit Information: Office Visit Copay: _____ Deductible: _____ (Circle One)
 Coinsurance %: _____ Maximum Out-Of-Pocket or Stop Loss: _____ OOP / SL
 Pharmacy Plan: _____ Other (Vision/Dental): _____

IMPORTANT: In order to ensure accurate quotes, you must provide the age & gender for all dependents on this census form otherwise your rates are subject to change at the time of enrollment.

	Name	Home Location	ZIP	Hours per Week	Male / Female M/F	Date of Birth	Enrollment Status				COBRA? Y/N	Reason for Not Enrolling			
							Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family		Other Group Coverage	In Probationary Period	Not Eligible	Other
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

Please fax, mail or email this form to Cassandra Wick at the Agri-Business Council of Oregon
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