

Group Proposal Request (2-50 Employees)

Group Information

Group Name:		Industry:		Inception Date:	
Group Address:				Zip Code:	
Total # Active Employees (Part-time, Full-time, Opt-Outs, & Leased):		Total Working 17.5 or More Hours/Week:		Total Waiving:	Total Enrolling:
Minimum Hours:		Qualification Period:		Employer Contribution: Employees: % Dependents: %	
Current Medical Carrier:		Current Dental Carrier:		Desired Effective Date of Quote:	
Agent Name:		Agent Phone:	Agent Fax:	Agent E-Mail Address:	

Employee Census (Please list all employees on payroll.)

Tier: EO = Employee Only / ES = EE + Spouse / EF = EE + Family / EC = EE + Child(ren)

Status: E = Eligible / NE = Not Eligible Due To Hours / C = COBRA/Continuation / PP = Probationary Period/ W = Waiving

Reason Waiving: OG = Other Group Coverage / OI = Other Individual Coverage / OP = Other Publicly Sponsored Plan
OHP = Oregon Health Plan / M = Medicare/Medicaid / DW = Does Not Want

	Employee Name	Sex M/F	Married Y/N	Birth Date or Age	Tier	Status E-NE-C P-W	Reason Waiving	Hire Date	Hours Per Week	Zip Code
1										
2										
3										
4										
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Employee Census (Continued. Please list all employees on payroll.)

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	Employee Name	Sex M/F	Married Y/N	Birth Date or Age	Tier	Status E-NE-C P-W	Reason Waiving	Hire Date	Hours Per Week	Zip Code
26										
27										
28										
29										
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