

**REQUEST FOR RATE QUOTE: Please complete and return to Fred Sampson phone 503.231.6399  
 FAX: 907-6548, or email: [frs@xprrt.net](mailto:frs@xprrt.net)**

Today's date:		Desired Effective Date		Group Contact:	
Group Name				Employer Contribution: Employees: %, Dependents %	
Address:				Zip Code:	
Phone #:		Fax#:		Email:	
Industry		Current medical carrier		Current dental carrier:	
Hours must work per week to be eligible for coverage:		Wait period for new employees (0,30,60 or 90 days):		Total # of employees working 17.5 or more hours/week)	
Total # of eligible employees:		Average # of employees last 12 months:		# of former employees on Continuation or COBRA:	

**Employee Census Form** (list all employees on payroll including part time and those in probationary period and former employees still on the group plan through state continuation or COBRA):

	Sex		Name	Weekly hours worked	Birth Date	Married?		# of Kids	Enrollment code*	Waiving Code*	Zip Code
	M	F				Y	N				
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

(use the next sheet/page to list additional employees )

*Enrollment Codes	
E	employee only
S	employee + spouse
F	employee +spouse + child(ren)
C	employee + child(ren)
W	waive
NE	not eligible due to hours
PP	probationary period
CONT	continuation/ COBRA

* Waiving Codes	
ID	has individual/family plan coverage
OG	has other group coverage
NC	No other coverage
GV	has government coverage