



625 Hawthorne SE
 PO BOX 12888
 Salem, OR 97301

Request For Group Insurance Quote

Please complete this form and fax back to CFP, Inc. attention Jolie Penrose at **1-503-365-2964** for a no-obligation quote.
To submit your request electronically, please include all requested information and email to joliep@cfpinc.net or billr@cfpinc.net.

Business Name:		Contact Name:	
Physical Address:		City/State:	Zip:
Phone:	Fax:	Email:	
Employer Pays _____ % of Employee premium _____ % of Dependent premium	Waiting Period _____ Required Hours _____	Management/Owners Only: <input type="checkbox"/>	All Eligible Employees: <input type="checkbox"/>
Current Health Insurance Carrier:		Deductible/CoPay:	
Please attach bill and benefit summary if available.			
Current Dental Insurance Carrier:		Deductible/Benefits:	

Please complete the following information for **every employee working a minimum of 17.5 hours per week**.
 Include COBRA /State Continuation Members.

Initials	Date of Birth	Gender	Zip Code	Age of enrolling Spouse / Domestic Partner	Age(s) of enrolling Children	Enroll Status <small>EE - Employee Only ES - Emp. + Spouse EF - Emp + Family EC - Emp + Children</small>	Reason not enrolled <small>G - Other Group Plan S - Seasonal /Temp H - Insufficient Hours P - In Waiting Period M - Medicare/Medicaid N - Not enrolling - Cost</small>	Hours Worked Per Week
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

Please make copies as needed for additional employees.

If you have questions, would like further information, or need assistance with this form, please call Jolie Penrose at 1-888-588-2988 ext 317 or Bill Russell ext 312.