

Thank you for considering BCI Group!

To research the most cost-effective plan that will best suit your employees needs, please provide the following information:

1. The following items about your business:

Group Name	
Type of Business	
Employer Entity (i.e. C Corp)	
Years in Business	
Contact Name	
Physical Address (all locations)	
Mailing Address	
Phone Number	
Fax Number	
Email Address	
Requested Eff Date	
Probationary Period	
Minimum Hours	
Employer Contribution	
Special Considerations	

2. Current plan info:

Medical:	Carrier:	Renewal Date:
Dental:	Carrier:	Renewal Date:
Vision:	Carrier:	Renewal Date:
Other:	Carrier:	Renewal Date:
Other:	Carrier:	Renewal Date:
Other:	Carrier:	Renewal Date:

3. Looking for:

Medical	Life	Include Domestic Partner
Dental	LTD	Cobra Services
Vision	STD	Group Retirement/401(k)
RX	HSA/HRA	Voluntary Benefits
Section 125	OSBA	Other
Alternative Care	EAP	Other
Quote Options		Match existing plan design

4. Complete the enclosed census form listing your employee information.
5. Please include benefit summaries and / or booklets.
6. Please include copies of your most recent bills for all lines of coverage.
7. Groups 2-4 need to include Payroll Records (form OQ & form 132).
8. Oregon Employers need to complete the Oregon Group Profile Form