

**Planning Resources Corporation**

**Group Health  
Proposal Request**

Please Fax to: (503) 227-0971

Company Name: \_\_\_\_\_

Administrator Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone : \_\_\_\_\_ Fax: \_\_\_\_\_

Current Carriers: \_\_\_\_\_

Probationary Period: 30                      60                      90  
(Please Circle )

Total Hrs/Week: \_\_\_\_\_

Years in Business: \_\_\_\_\_

Renewal Date: \_\_\_\_\_

Contribution Amounts \_\_\_\_\_ % Employee                      \_\_\_\_\_ % Dependents

Plans/Rider Options:            HMO                      CHIROPRACTIC                      NATUROPATHIC  
(Please Circle )  
   PPO                      VISION                      DENTAL

<u>CURRENT RATES</u>	Employee Only	EE + Spouse	EE + Family	EE + Child
Medical /Rx				
Dental				
Vision				

<u>RENEWAL RATES</u>	Employee Only	EE + Spouse	EE + Family	EE + Child
Medical /Rx				
Dental				
Vision				

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Must have at least 75% of employees participating for a sma  
Minimum of three employees for dental plans.*