Willamette Valley Benefits, Inc.

Individual and Family Plans Medical Review Form

(Not Medicare)

Name: _____ DOB: _____

Address: _____ Gender: _____

_____ County: _____

☐ Check box if this is a new address, e-mail or phone number.

Phone: _____ Tobacco: ☐ Yes ☐ No

Current Insurance Plan: _____

Preferred Email: _____

By providing your e-mail you are authorizing Willamette Valley Benefits, Inc. to include you on our e-mail list and receive periodic e-mails from Willamette Valley Benefits, Inc.

By returning this completed form, you are agreeing to have a representative of Willamette Valley Benefits, Inc. contact you regarding the information you provide below.

In the next few lines please list any spouse/domestic partner and dependents.

Family Information	DOB	Tobacco Y/N
Spouse/Domestic Partner:		
Dependent:		
Dependent:		
Dependent:		
Dependent:		

In the Next few lines please provide a list your **top three doctors in order of priority**.

Hospital & Doctor's Name	Hospital & Doctor's Phone Number
Hospital:	
Primary Care:	
Specialist:	

Please return to:
Willamette Valley Benefits, Inc.
6400 SE Lake Road, Suite 210
Milwaukie, OR 97222

Phone: 503.659.5566
Toll Free: 1.888.944.4644
Fax: 503.659.5992

How did you hear about Willamette Valley Benefits, Inc.? _____

If already a client of Willamette Valley Benefits, Inc., who is your insurance agent? _____

****NOTE: We are not responsible for checking your prescription drug coverage with your insurance carrier. You can call your insurance carrier directly for this information.**