Willamette Valley Benefits, Inc.
Medical Review Form

Name:______________________________ DOB:____________ Gender:__________
Preferred Effective Date:________________

Address:____
Street Address *Apt/Suite#*

____
City *State* *Zip Code* *County*

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

Phone:______________________________________ Tobacco: Y ☐ N ☐

Preferred Email:____
By providing your email you are authorizing Willamette Valley Benefits, Inc. to include you on our email list and receive periodic emails from Willamette Valley Benefits, Inc.

Current Insurance Carrier/Plan Name:___________________________________

Hospital & Doctor's	Doctor's Phone Number		
Hospital:			
Primary Care Physician:			
Specialists:			
Prescriptions	**Dosage**	**Per Day**	**Brand/Generic**
Pharmacy:			

If you have additional Doctors or Prescriptions, please attach a list to this review form.

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
www.wvbenefits.com

How did you hear about Willamette Valley Benefits, Inc? ______________________________

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

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.