Willamette Valley Benefits, Inc.

Individual and Family Plans Medical Review Form

(Not Medicare)

Name:_____ DOB:_____ Gender:_____

Preferred Effective Date:_____

Address:_____

Street Address *Apt/Suite#*

_____

City *State* *Zip Code* *County*

Tobacco: ☐ Y ☐ N

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

Home Phone:_____ Cell Phone:_____

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: _____

****Please list only spouse/domestic partner & dependents that need coverage.**

Household Size: _____

Family Information	DOB	Tobacco Y/N	Gender
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: Willamette Valley Benefits, Inc. is not responsible for checking your prescription drug coverage with your insurance carrier. You can call your insurance carrier directly for this information.**

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.

Additional Notes: