



Producer Request for Benchmark Analysis

Complete this form for every plan you want to benchmark and send to FHIAP with benefit booklet and prescription drug plan information.

| | | | |
|---|------|---|------|
| Employer name: | | Federal Employer Identification Number (EIN): | |
| Employer address: | | | |
| City: | | State: | ZIP: |
| Employer benefit contact name: | | | |
| Phone: | Fax: | E-mail: | |
| Name of insurance company: | | | |
| Plan number: | | Group number: | |
| Plan anniversary or renewal date: | | Plan purchase pending? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Proposed effective date: | |
| What type of health benefit plan is offered or being purchased? <input type="checkbox"/> Traditional-indemnity <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> Other (please specify): _____ | | | |
| Industry type: <input type="checkbox"/> Construction <input type="checkbox"/> Manufacturing <input type="checkbox"/> Retail <input type="checkbox"/> Finance <input type="checkbox"/> Health Care <input type="checkbox"/> Hospitality <input type="checkbox"/> Other (please specify): _____ | | | |
| Name of person (producer) requesting benchmark analysis: | | | |
| Title: | | | |
| Phone: | Fax: | E-mail address: | |
| Additional comments? (See page 2) | | | |

Please send this form, benefit booklet and prescription drug plan to:

E-mail:

fhiap.mail@state.or.us
 Attn: Benchmarking
 (include employer's name in subject line)

OR

Mail:

FHIAP
 Attn: Benchmarking
 P.O. Box 5880
 Salem, OR 97304-0880

OR

FAX:

1-866-843-8936
 Attn: Benchmarking

Questions? E-mail: fhiap.mail@state.or.us Attn: Benchmarking.

