



Century Benefits

Please fax this completed form to 503-922-2348

Company Information

Company Name _____ Contact _____
 Address _____ State _____ Zip Code _____
 Phone _____ Fax _____ Type of Industry _____
 County _____ Effective Date _____ Waiting Period (0-90 days) _____
 Current Carrier _____ Premium _____ Deductible _____ Copay _____

Please list all eligible employees (those working a minimum of 17.5 hours per week)

	Employee Last Name	Sex	Tobacco Y/N	DOB mm/dd/yy	Dependents		Weekly Hours	Enrollment Code	Waiving Code	Zip Code
					Spouse	# of kids				
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										

If more than 14 employees please use additional forms

Enrollment Codes	
E	Employee Only
S	Employee and Spouse
F	Family
C	Employee

Waiving Codes	
F	Contracted Employee
I	Other Ind. Coverage
V	Veteran Coverage
H	Hours Insufficient
W	Waived Coverage
S	Dependent of Employee
G	Other Group Insurance
M	Medicare