Premium Only Plan (POP) Application

683706676 (4/20)

PLEASE PRINT CLEARLY

Section 1 Company information

Employer name			
Administrative Contact		Title	
Phone	Fax	Email address	
Address	City	State	ZIP
Business Structure ☐ C-Corporation ☐ S-Corporation ☐ LLC ☐ LLP ☐ Public ☒ Non-Profit			
No. of EEs	Original Effective Date	Plan Year	

Section 2 Agent information

Agent Name		Agency	
Phone		Email address	
Address	City	State	ZIP

Section 3 Other BenefitHelp Solutions or Moda/Delta Dental business

☐ COBRA ☐ HRA ☐ Moda medical ☐ Delta Dental of OR or AK dental ☐ FSA (POP should not be used if an FSA is in place; please call for more details)

Please mail completed application along with paid invoice to:
BenefitHelp Solutions, Sales and Account Services, P.O. BOX 67230, Portland, OR 97268-1240