

Group Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Employee Waiting Period: \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_ Total Number of Full Time Employees: \_\_\_\_\_

Please check all of the following benefits that are currently offered and if they are employer, employee paid or check both if it is applicable.

<b>BENEFIT</b>	<b>CURRENTLY OFFERED</b>	<b>EMPLOYER PAID</b>	<b>EMPLOYEE PAID</b>
<b>CORE BENEFITS</b>			
<i>Group Health</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Dental</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Vision</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Life</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group AD&amp;D</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Long Term Disability</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Short Term Disability</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Group Long Term Care</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Employee Assistance Plan</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Retirement Plan</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>SUPPLEMENTAL PLANS</b>			
<i>Voluntary Life</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Voluntary Short Term Disability</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Voluntary Cancer</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Voluntary Accident</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Voluntary Medical Gap Plan</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Voluntary Critical Illness</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>ADMINISTRATION PLANS</b>			
<i>Section 125</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Flexible Spending Account</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Dependant Care Account</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Web Portal for Benefit Access</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Current Health Plan Carrier: \_\_\_\_\_

Renewal Date: \_\_\_\_\_ Type Funding: Fully Insured  Self Insured

Total # of Employees: \_\_\_\_\_ Total # of Covered Employees: \_\_\_\_\_

Current Monthly Premiums: Single: \_\_\_\_\_ Family: \_\_\_\_\_

Employer Contribution: Single: \_\_\_\_\_ Family: \_\_\_\_\_

Employee Contribution: Single: \_\_\_\_\_ Family: \_\_\_\_\_

**Needed Information:**

- Please provide copies of up to last three years renewal letters and experience for those years if self-funded.
- Most recent monthly invoice
- Census to include

Current Dental Plan Carrier: \_\_\_\_\_

Renewal Date: \_\_\_\_\_ Type Funding: Fully Insured  Self Insured

Total # of Employees: \_\_\_\_\_ Total # of Covered Employees: \_\_\_\_\_

Current Monthly Premiums: Single: \_\_\_\_\_ Family: \_\_\_\_\_

Employer Contribution: Single: \_\_\_\_\_ Family: \_\_\_\_\_

Employee Contribution: Single: \_\_\_\_\_ Family: \_\_\_\_\_

**Needed Information:**

- Please provide copies of up to last three years renewal letters and experience for those years if self-funded.
- Most recent monthly invoice
- Census to include

For the benefits that you currently offer, please attach copies of the following (if applicable):

- Last Invoice
- Group Summary Plan Document
- Individual Benefit Summaries for Voluntary Benefits
- Retirement Plan Fees and copy of Plan Document

Please provide in electronic format (preferably excel) employee information to include:

Employee Name	Gender	Date of Birth	Date of Hire	Home Address	Annual Income	Job Description
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