Corporate Questionnaire

\*Companies should complete questions 1-12 and complete only the insurance areas for which they are interested in receiving proposals.

Many firms prefer to give us copies of their employee benefit booklets, and billing so we can extract this information for you.

1. Name of Firm:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please give a brief description of primary business:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. SIC code (if known)\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How Long In Business\_\_\_\_\_\_\_\_\_\_\_\_
3. Business Type\_\_\_\_C Corp\_\_\_\_\_\_S Corp\_\_\_\_\_\_LLC\_\_\_\_\_Non-Profit

\_\_\_\_\_\_\_Other

1. Employment Locations and number of employees at each (full address)

a.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ b.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ d.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Are Retired Employees Covered \_\_\_Yes \_\_\_No

1. Are any covered employees paid on 1099 basis only\_\_\_Yes\_\_\_No
2. What is the waiting period for benefits for new hires?\_\_\_\_\_\_\_\_\_\_\_\_
3. Is the plan centrally administered? \_\_\_ Yes \_\_\_\_No
4. Number of eligible employees\_\_\_\_\_\_\_\_ Number enrolled\_\_\_\_\_\_\_

Group Life/Group AD&D:

Schedule of Benefits-

Flat Amount per Employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Multiple of Salary\_\_\_\_\_\_\_\_\_\_\_\_\_ Maximum Amount

Age Reduction Schedule\_\_\_\_\_\_%65 \_\_\_\_\_\_\_\_%70 \_\_\_\_\_Other

Accelerated Death Benefit\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No

Conversion Option\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_No

Premium Waiver\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_No

Seat Belt Benefit\_\_\_\_\_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No

Current Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Renewal Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Combined Rate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per$1,000

Current Volume\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Contribution Percentage\_\_\_\_\_\_\_\_\_

Dependent Life Option\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No

Group Long Term Disability

Elimination Period\_\_\_\_\_\_\_\_\_\_\_\_\_\_Days

Definition of Disability \_\_\_\_\_\_\_\_Own Occupation to 65 \_\_\_\_\_\_\_24 Month Own Occupation \_\_\_\_\_\_\_\_\_Executive Carve Out

Monthly Benefit Percentage\_\_\_\_\_\_\_\_\_\_%

Monthly Benefit Maximum\_\_\_\_\_\_\_\_\_

Minimum Monthly Benefit\_\_\_\_\_\_\_\_\_\_

Conversion Option\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_No

Premium Waiver\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_No

Survivor Benefit\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_No

Mental/Nervous Limitation \_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

Self-Reported Disabilities Limit \_\_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_\_\_\_No

Definition Of Earnings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Pre-Existing Limitation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Current Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Rate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per $100

Current Volume\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Renewal Date-

Any Employees Out on Disability\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

If Yes:

Date of Disability-

Date of Birth-

Prognosis/Diagnosis(if known)-

Group Short Term Disability

Elimination Period for Accident\_\_\_\_\_\_\_\_\_\_Day(s)

Elimination Period for Illness\_\_\_\_\_\_\_\_\_\_\_\_Day(s)

Weekly Benefit Percentage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Benefit Maximum\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benefit Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weeks

Definition of Earnings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Current Carrier-

Current Rate\_\_\_\_\_\_\_\_\_\_\_\_\_\_per $10

Current Volume\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Employees currently out on short term disability\_\_\_\_\_\_Yes\_\_\_\_\_No

If Yes:

Date of Disability-

Date of Birth-

Prognosis/Diagnosis(if known)

Group Dental Insurance

Traditional Indemnity or Out of Network Benefits In-Network

Deductible Amount Ded.Amt.

Family Deductible Limit FDL

Deductible Apples to Preventive Services \_\_\_Yes \_\_\_No “ “

Preventive Services \_\_\_\_% PS\_\_\_\_%

Basic Services\_\_\_\_% BS\_\_\_%

Major Services\_\_\_% MS\_\_%

Annual Maximum per Insured\_\_\_\_\_\_\_ AM\_\_

Orthodontia\_\_\_\_ Ord\_\_%

Orthdontia Ded\_\_\_ “ “

Lifetime Ortho Limit\_\_\_\_\_ “ “

Endontics Services \_\_\_\_\_\_Basic Service \_\_\_\_\_\_\_\_Major Service

Periodontic Services\_\_\_\_\_\_ Basic Service \_\_\_\_\_\_\_\_Major Service

Current Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Renewal Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Rate\_\_\_\_\_

Employee/Spouse Rate\_\_\_\_\_\_\_

Employee/Child(ren) Rate\_\_\_\_\_\_\_

Family Rate\_\_\_\_\_\_\_\_

Employer Contribution for Employee Premium\_\_\_\_\_\_\_\_%

Employer Contribution for Dependents Premium\_\_\_\_\_\_\_\_%

Point of Service/Preferred Provider Organizaton Benefits Schedule

In-Network Out-of-Network

$\_\_\_Office Copayment Deductible\_\_\_\_\_

$\_\_\_\_Specialist Copayment Family Deductible Limit\_\_\_\_\_

$\_\_\_\_Hospital Copayment Coinsurance \_\_\_\_%

$\_\_\_\_Emergency Room Copay. Individual Coinsurance Max.\_\_\_\_

Prescritpions Family Coinsurance Max.\_\_\_\_\_\_

$\_\_\_\_Generic Copayment Lifetime Maximum\_\_\_\_\_\_\_\_\_\_\_

$\_\_\_\_Preferred Brand Copayment

$\_\_\_\_Non\_Preferred Copayment

$\_\_\_\_Mail Order Copayment

Lifetime Maximum\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Carrier\_\_\_\_\_\_\_\_\_\_\_

Renewal Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Rate\_\_\_\_\_\_\_\_\_\_\_\_\_\*

Employee/Spouse Rate\_\_\_\_\_\_\_\_\*

Employee/Child(ren) Rate\_\_\_\_\_\_\*

Family Rate\_\_\_\_\_\_\_\_\_\_\_\_\_\*

\* For Partial Self-Funded Plans give COBRA equivalent

Employer Contribution for Employee Premium\_\_\_\_\_\_\_%

Employer Contribution for Dependent Premium\_\_\_\_\_\_\_%

Note:

For Indemnity Plans Fill Complete Out-of-Network Benefits only.

For Partial Self-Funded Programs Please Complete Separate Reinsurance Questionnaire.

Partial Self-Funded Plan Reinsurance Information

Individual Specific Amount\_\_\_\_\_\_\_\_\_\_\_\_

Family Specific Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Type\_\_\_\_\_\_\_\_\_\_Incurred\_\_\_\_\_\_\_\_\_\_Incurred/Paid\_\_\_\_\_\_Paid

Ex. 12/15 Incurred/Paid

Aggregate Limit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aggregate Type\_\_\_\_\_\_\_\_Incurred\_\_\_\_\_\_\_\_\_Incurred/Paid\_\_\_\_\_\_\_Paid

Ex. 12/12 Incurred/Paid

Fees:

Individual Specific Premium\_\_\_\_\_\_\_\_\_\_\_

Family Specific Premium\_\_\_\_\_\_\_\_\_\_\_

Aggregate Premium per Employee\_\_\_\_\_\_

Utilization Review Fee per Employee\_\_\_\_\_\_

PPO Access Fee per Employee\_\_\_\_\_\_\_\_\_\_

Monthly Administration Fee per Employee\_\_\_\_\_\_\_\_\_\_\_

Misc. Fees\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Note This Area Should Be Completed with the Point of Service/Preferred Provider Organization Schedule of Benefits Section)

Long Term Care Plans- The employer questionnaire should be completed by early next week.

Employee Paid Voluntary Programs- Please indicate which area(s) that you are interested in receiving information about:

\_\_\_\_Life Insurance \_\_\_\_Dental Insurance \_\_\_\_\_Disability Insurance \_\_\_\_\_Long Term Care Insurance

Executive Benefits- Please indicate which area(s) that you are interested in receiving information about:

\_\_\_\_\_\_Key Person Insurance

\_\_\_\_\_\_Non-Qualified Deferred Compensation

\_\_\_\_\_\_Executive Bonus

\_\_\_\_\_\_Split Dollar Life Insurance

\_\_\_\_\_\_Buy/Sell Cross-Purchase Plan

\_\_\_\_\_\_Buy/Sell Stock Redemption Plan

\_\_\_\_\_\_Overhead Expense Protection

\_\_\_\_\_\_Non-Qualified Salary Continuation

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