



GETTING STARTED with Employer Groups

There are a few things we will need from you in order to get started. Most of it is self-explanatory, but if you need help give us a call at (702) 892-0266. When finished, fax all completed pages to us at (702) 892-0212 or email to your broker, call for email address.

Contact Information

Name: _____ Title _____

Email address: _____ Broker _____

Business Information

Legal Business Name: _____

DBA: _____ in Business: Yrs. _____ mos. _____

Corporate Address: _____

City: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____

Do you have multiple locations: _____ If so, list with zip-codes _____

Do you have out of area/state employees to cover? _____ If so, list with zip-codes _____

Nature of your Business: _____

Are you a Chamber of Commerce member? _____ If so, which Chamber(s): _____

Number of full-time employees: _____ Part-time: _____ Total: _____

Can you provide the most recent Quarter's State Wage and Tax report? Yes No

Any 1099 labor/workers? Yes No 1099's represents _____ % of our workforce.

Approx number of employees who will be enrolling in the plan: _____



Percent of insurance premium the employer will pay toward employees health plan(s) _____

50% 75% 99% Other amount _____ Any toward Ancillary Products? _____

Any toward their dependents? _____ 50% 75% 99% Other amount _____

Your Current Group Health Insurance Situation

Do you have existing group health coverage? _____ IF YES...

Name of current group health insurance company? _____

Month of renewal for current coverage: _____

Number of employees currently enrolled in group plan: _____

Do you have an existing broker? _____

Please indicate the group insurance products you are interested in:

- Health Vision Dental Life Long-term disability Short-term disability
401K Section 125 Cancer AD&D HDHP w/HSA Pension Plans
Long Term Care Voluntary Products Other _____

Additional Comments

Please include short comments regarding any known on-going medical conditions or prescriptions among the employees and dependents to be covered by the health plan (if already known to you - do not include the person's names).

Four horizontal lines for writing additional comments.



Are there any other issues you want us to consider? If so, please summarize: _____

Proceed to complete and include the attached employee census information form.

CENSUS FORM

Employee Census Information						
	Employee Name	DOB/Age	Sex	Dependent Status	Spouse DOB/Age	# Children
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

Attach additional forms if necessary.

Dependent Status:

Employee only = EE

Employee + Spouse = EE + Spouse

Employee + Child or Children = EE + Child(ren)

Employee + Family = EE + Family