GROUP INSURANCE CENSUS FORM - HEALTH, DENTAL, LIFE, VISION & DISABILITY

Company Name:	**Type of Businesas**
Contact:	
Address:	
City: **State:** **Zip:**	**Return form to:**
Telephone: **Fax:**	**Financial Alternatives, Inc.** 7527 Woodcrest Road Baldwinsville, New York 13027 **Phone:** 315.622.7000 **Fax:** 315.622.4142
Email:	**Email:** ajanthony@gmail.com

	EMPLOYEES INFORMATION					DEPENDENTS	
	EMPLOYEE NAME OR ID CODE	**M/F**	**BIRTHDATE**	**HOME ZIP CODE**	**ANNUAL INCOME (FOR DISABILITY & LIFE)**	**SPOUSE/ PARTNER (Y/N)**	**NUMBER OF CHILDREN**
1							
2							
3							
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EFFECTIVE DATE SOUGHT:	**EXISTING CARRIER:**

CONFIDENTIAL GROUP HEALTH INSURANCE FIELD UNDERWRITING QUESTIONNAIRE

Our approach is to understand your unique Group Health Insurance needs and address your concerns. Your input will help us to formulate our approach to all the carriers. Thank you very much.

1. Please complete the census and provide information for your existing plan(s):

LIFE BENEFIT:	STD DURATION:	STD BENEFIT:	LTD BENEFIT:
ADDITIONAL REQUESTS:			

2. Briefly explain any concerns your group may be experiencing with your current carrier(s), insurance plan(s) or other:

3. Provide the following information for your existing plan(s) :

COVERAGE TYPE	CARRIER	PLAN DESCRIPTION	RENEWAL DATE
MEDICAL			
DENTAL			
LIFE			
VISION			
SHORT TERM DBL *Usually NYS Dbl*			
LONG TERM DBL			
401(K)			

4. In order to manage the cost of your benefits program, would you like to: Check all that apply:

- ☐ Learn about Health Savings Accounts (HSA)
- ☐ Offer HMO
- ☐ Offer PPO
- ☐ Offer a multiple plan approach

5. If employees contribute to their premiums or they pay for their dependent costs are these premiums paid on a:

- ☐ Pre-tax basis
- ☐ Post-tax basis