www.Mertz Insurance Group.com

Phone 208.412.4128

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Questionnaire:

Name of Business: ____ Effective Date: ________________

Primary Contact Info: ____ EIN#: _______________________

Physical Address City, State & Zip code: ____

Mailing Address City, State & Zip code: ____

Phone: _____________________ Fax: _____________________ Email: ______________________________

Eligibility:

of total employees (full **AND** part time): _________ # of **eligible** employees: __________

If employee works 30 hrs. or more, they must be counted full time/eligible

Probation Period: 1st of the month following **30** or **60** days **(circle one)**

Employer Contribution: What percentage of premium do you want to contribute?

	Medical	Dental	Vision
Employee:	________%	________%	________%
Dependents:	________%	________%	________%