MORSE INSURANCE AGENCY

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PEO Request for Proposal

Requested Effective Date: _____

Client [Legal] Name_____ DBA _____

Client Company Contact _____Title_____

Locations:
Please attach a list with all location addresses _____

Phone _____Fax _____Email_____

#FT Employees _____#PT Employees _____#Contract Employees _____#Locations_____# of Entities _____

FEIN#_____ Nature of Business _____SIC Code _____

Payroll Frequency:

Weekly_____Bi-weekly_____Semi-monthly_____Monthly_____Gross Annual Pay _____

Current payroll provider and annual cost if outsourced _____

State unemployment rate(s) _____

Employment practices liability insurance-annual cost (if applicable) _____

Employment attorney-HR outsourcing-annual cost (if applicable) _____

Outsourced services annual cost (COBRA, unemployment claims management, HR collateral, HR or WC trainings, etc)

_____

_____

Benefits Requested - please check all that apply

Health___ ____Dental____ ____Life_____LTD_____ STD _____401(k) Plan _____

Employer Contribution Towards

Health_____ Dental____ ____Life_____LTD_____STD ___ ___401(k) Plan _____

Documentation <u>Required</u> for Proposal (for each state of operation):

- Last 4 quarters state unemployment return (summary page only) or NJ 927 in NJ
- Copy of workers compensation declaration pages(s), including detail of payroll by WC class, modifier, and any applicable premiums, discounts or surcharges
- Three years workers' compensation loss runs
- Recent healthcare billing, explanation of coverage, renewal (if applicable)
- Census information
- Health questionnaire
  (Groups with less than 25 employees enrolled on benefits may be required to complete individual medical questionnaire)
- If 100+ people on healthcare, medical loss runs (or last renewal and upcoming renewal with claims information)
- If the client is with an existing PEO you need to provide the most recent invoice and a description of benefits with current renewal dates
- For NY groups: copy of DBL bill

Group Health Questionnaire

Next, please answer the following questions on behalf of your company to the best of your knowledge.
You may include additional sheets for detailed explanations.

IV. SERIOUS ILLNESS / CONDITION QUESTIONS:		To the Best of My Knowledge
A.	Has employee, dependent, or Cobra participants incurred over $5,000 in claims in the last 12 months?	Yes No
B.	Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?	Yes No
C.	Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	Yes No
D.	Has the company received a Decline to Quote by any carrier or PEO in the past 3 years?	Yes No

E. Is anyone currently being treated or been advised to seek treatment for any of the following?

Please check all that apply:

- ☐ AIDS or testing HIV positive
- ☐ arthritis
- ☐ back disorder
- ☐ cancer
- ☐ diabetes
- ☐ heart disease
- ☐ kidney disorder
- ☐ liver disease
- ☐ mental illness
- ☐ muscular disorder
- ☐ nervous system disorders
- ☐ respiratory disease
- ☐ stroke
- ☐ substance dependency
- ☐ transplants
- ☐ tumor
- ☐ other serious conditions
- ☐ alcohol/drug abuse
- ☐ blood disorder
- ☐ stomach disorder
- ☐ multiple sclerosis
- ☐ muscular dystrophy

For all checked boxes please provide details below:

M/F	Age	Condition	Date of Onset	Last Treated Date	Treatment/Drug	Degree of Recovery

Group Health Questionnaire

List any current COBRA/State Continuation participants: **NONE**

Name/DOB/Phone# of Individual	COBRA Continuation Effective Date	Activating Event/Date (i.e. employee termination, etc.)

List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date: **NONE**

Name/DOB/Phone# of Individual	Date Eligible	Activating Event/Date

Is anyone currently pregnant?

If yes, please provide due date and note below if normal, high risk, multiple birth or preterm labor with pregnancy. This includes employees, dependents or COBRA participants.

Due Date	Type of Pregnancy or Condition (normal, high-risk, preterm labor, etc.)

The information gathered is for actuarial use only. This information is not be used in connection with any decisions or actions regarding any individual's employment.

Because actuarial analysis requires current, accurate information, this questionnaire expires after 60 days from the date signed below. After that time, a new questionnaire will be required.

I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

Authorized Signature	Title	Date
Print Name	Name of Company	