DETAILS OF YOUR COMPANY & BENEFITS

Please complete "ALL" fields

1. Company Name (dba): _____ TIN: _____

2. Employees: Full time count: ____ Part-time count: ____ Seasonal count: ____ Number of payroll periods:____

3. Complete mailing address: _____

4. Contact person (person responsible for compliance): _____Title: _____

5. Contact e-mail: _____ Contact phone: ( ) _____ Ext: _____

6. Is there a Section 125 premium conversion plan (PCP) in place? **[ ]** Yes **[ ]** No PCP plan document? **[ ]** Yes **[ ]** No

7. Eligibility: coverage begins**: [ ] 1st** of the month following waiting a ___- day waiting period / **[ ]** Date of hire

8. Coverage terminates: **[ ]** immediately upon termination **[ ]** end of the month after termination

9. Employee classes? _____ Are you covering Domestic Partners (ASO/LSF plans)? ____

11. Is there an HRA plan? **[ ] Yes [ ] No** Administrator: _____

12. Are HSA options offered? **[ ] Yes [ ] No** Bank or administrator: _____

13. Previous year Medical Plan company cost: $_____ Current year: $_____

14. Company contribution strategy (medical, dental, etc.): _____

15. Current Plans Offered – ***please complete the section below***

Plan	Carrier	Policy Number	Month Effective	(V)ol or (C)ontrib	(F)ully Ins. or (S)elf Ins.	Count of Enrolled Employees				Eligible Hours to Join	Eligible Days to Join
						S	C	2P	F		
Medical Plan											
Group Life											
Voluntary Life											
Group STD											
Group LTD											
Group Dental											
Group Vision											
Flex Benefits											
Pension Plan											
Executive Life											
Executive DI											

16. Secondary location to be included: _____

NOTE: The information you provide on this form is strictly confidential and will not be shared outside the quotation process.

PLEASE RETURN YOUR COMPLETED FORM BY ANY OF THE FOLLOWING METHODS: By Email: admin@benefitsvt.com
By Fax: (802) 448-5902

Benefits Inc.