Group Medical Plan Questionnaire

PARTNERS IN BENEFIT PLANNING, INC.

2000 S.E. 15TH Street, Building 400-E
Edmond, OK 73013

PHONE (405) 330-4015 **FAX (405) 330-1917**

Date:_______________ **Proposed Effective Date:________________**

COMPANY NAME	ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER	TYPE OF INDUSTRY	SIC CODE	

Plan Information

Current group health plan carrier _________________________ ☐ None Renewal Date:_____________

Deductible _________ Office Visit Copay ___________ Prescription Copay ____________

Please provide a current copy of the billing and summary of benefits with your current carrier.

Below list your current rates and the last rate increase %: Employer contributions ($ or %):_______________

EMPLOYEE	EE+SPOUSE	EE+CHILD	EE+FAMILY	% INCREASE		EE	EE+SPOUSE	EE+CHILD	EE+FAMILY

What type(s) of medical plan options would you like to have available?
☐ HMO ☐ PPO ☐ POS ☐ Other (Describe)________________________ Deductible _________

Office Visit Copay ________ Rx Copay ________ Max. out-of-pocket __________Maternity ☐ Yes ☐ No

Dental Carrier _____________ Type of coverage _____________(Please provide a summary of benefits)
Dental Renewal Date ____________________ Do you wish to receive dental quotes? ☐ Yes ☐ No

Life Insurance Carrier _______________ Type/Amount of coverage ________________________________
Life Renewal Date ___________________ Do you wish to receive life quotes? ☐ Yes ☐ No

Group Information

1) Total number of employees on payroll/quarterly wage & tax statement _______ (list all ee's on census)
2) Total number enrolled in the current health plan or likely to enroll _____________
3) Do all employees work 25 or more hrs? ☐ Yes ☐ No If No, # of Part-Time_____ # of Full-Time_______
4) Do you offer COBRA? ☐ Yes ☐ No If Yes, # _____ and please indicate COBRA participants on census.
5) Waiting period for new hires? _________________________
6) Are Retirees covered? ☐ Yes ☐ No If Yes, # _____ and please indicate retirees on your census.
7) Do you have other locations? ☐ Yes ☐ No If Yes, list locations *including Zip Codes* on separate sheet **AND** indicate which employees work at which location on your census.
8) Other coverages you are interested in: ☐ Short Term Disability ☐ Long Term Disability ☐ Long Term Care ☐ Voluntary Life ☐ Voluntary Dental ☐ Retirement Plans ☐ ________________

(Use additional pages if necessary to answer all questions)