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

RxMom.com
Life. Health. Dental and Disability Insurance

Company Name:_____

Contact: _____Type of Business_____

Address:_____

City: _____ State: _____ Zip:_____

Telephone: _____Fax:_____

Email:_____

Return to: Tom Musembi
RxMom.com Insurance Services
Insurance@RxMom.com
Fax: 866-707-9532
Bus: 888-490-8782

	EMPLOYEE					DEPENDENTS			
	EMPLOYEE NAME	M/F	BIRTHDATE	HOME ZIP CODE	ANNUAL INCOME (FOR DISABILITY & LIFE)	SPOUSE / PARTNER (YES/NO)	SPOUSE / PARTNER GENDER	NUMBER OF CHILDREN	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
	EMPLOYEE NAME	M/F	BIRTHDATE	HOME ZIP CODE	ANNUAL INCOME (FOR DISABILITY & LIFE)	SPOUSE / PARTNER (YES/NO)	SPOUSE / PARTNER GENDER	NUMBER OF CHILDREN	
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									

QUOTES REQUIRED : [ ] MEDICAL INSURANCE. [ ] DENTAL . [ ] VISION. [ ] SHORT TERM DISABILITY. [ ] LONG TERM DISABILITY

EFFECTIVE DATE SOUGHT:	CARRIERS REQUESTED:

LIFE BENEFIT:	STD DURATION:	STD BENEFIT:	LTD BENEFIT:	

ADDITIONAL REQUESTS:

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Confidential Group Health Insurance Field Underwriting Questionnaire

Our approach is to become more intimate with your unique Group Health Insurance needs in order to address your concerns and streamline the bidding process. We appreciate your valuable time for answering each of the questions below and sincerely look forward to serving you and building a long-term relationship. Thank you very much.

Company Name: Contact: Tel:

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

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

3. Summarize your company's goals, objectives and expectations for this exercise.

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

COVERAGE TYPE	CARRIER NAME 1	PLAN NAME 1	CARRIER NAME 2	PLAN NAME 2	RENEWAL DATE 1	RENEWAL DATE 2	MO. PREM. CARRIER 1	MO. PREM. CARRIER 2
MEDICAL								
DENTAL								
LIFE								
VISION								
SHORT TERM DISABILITY								
LONG TERM DISABILITY								
401(K)								

5. In order to manage the cost of your benefits program, would you like to: (Choose Letter(s) _____
   a. Learn about "Consumer Driven Plans"
      i. Health Savings Accounts
      ii. Health Reimbursement Accounts
   b. Learn about "Employer Defined Contribution" programs
   c. Learn about "Minimum Premium Funding" (requires 25+ participants)

6. In designing your medical insurance plan, mark "XXX" your preference from the following options:

Dr. Co pay	$10	$15	$20	$25	Other
Deductible	$250	$500	$750	$1000	Other

7. In designing your medical insurance program, would you like to: (Choose Letter) _____
   a. Offer PPO only
   b. Offer HMO only
   c. Offer a combination of HMO *and* PPO plan options

8. If employees contribute to their premiums or they pay for their dependent costs, are these premiums paid on a: (a) Pre-tax *or* (b) Post-tax basis? (Choose Letter) _____

9. How important is it to offer Kaiser? (Choose Letter) _____
   a. Not important b. Somewhat important c. Very important