Proposal Request Form

CPEhr's Contact: Preston Gould, Senior Business Consultant, 310-270-9865 pgould@cpehr.com

GENERAL INFORMATION

Producer Name: ____________ Date: ________ Current W&B Customer: Y N

Corporate Name/Address: ______________________ DBA: ____________

Contact Name and Title: ______________________ SIC code: ______ SUI rate or State ID # ____________

Phone # ____________ Website ____________ Email: ____________

Description of operations:____

Type of entity: Corp; Sole Prop; Partner Yrs in Bus. ___ EPLI: Yes No If yes, annual cost $_______ Fed ID # ____________

Ownership (names & %): 1) %; 2) %; 3) %

Does the owner of this company own 51%+ of any other entities? Yes No If yes, which ones and % of ownership?

WORKERS' COMPENSATION INFORMATION

1) Copy of Declaration Page (income per class code), 2) Last Bill, and 3) 3 yrs currently valued loss runs

Describe any hazardous conditions or any out-of-state travel; will certificates of insurance be needed?

PAYROLL

Total annual gross payroll $ ________ Are the employees all in the same entity? Yes No

Full time EEs ________ # Part time EEs ___________ States ___________________________ # of locations _______

Current pay cycle: Wkly BiWkly SMly

Annual cost of payroll processing:_______________ Vendor (ADP, Paychex,...): _________________

Pay day/date: Input on _______ Receive on _______ Pass out checks to employees on _______

Method of reporting hours: Spreadsheet___ Time clock report___Software___ Other___

BENEFITS

CPEhr Group Health Questionnaire, copy of last bill, census, last renewal information, copy of plan features; Enrollment Packet

Benefits offered: Medical_____ Dental____ Vision____ Group Life____ 125____ LTD____ STD____ 401k____(cost to admin. 401k)

Employer contrib. Employees: Medical ____ Dental____ Vision____ Group Life____ 125____ LTD____ STD____ 401k____

Employer contrib. Dependents: Medical ____ Dental____ Vision____

HUMAN RESOURCES

(helpful but not mandatory)

Who handles your day-to-day HR?_________________________ % of time spent on employee administration__________%

Have you had any labor related claims in the last 5 years? No ____ Yes:____

Up-to-date employee handbook? No Yes Prepared By:_______________ Cost: $_________

Do you offer employee training? No Yes Annual Cost: $_________ Would you like to offer training? __________

Do you have any employee relation issues? ____

Who guides you regarding terminations, discipline, labor law questions, unemployment claims? ______________________________

Existing vendors: Payroll___ Benefits___ 401k___ Training___ W/comp___ Recruiting___ Attorney__$___ EPLI___Other ___

Reason(s) why looking to Outsource: ____

What is your definition of HR...what's included. What kind of partner are you looking for?

What is your biggest challenge today regarding being an employer?

PRODUCER NOTES: Include workers comp Y N --- Include 401k Y N

GROUP MEDICAL/DISABILITY HISTORY QUESTIONNAIRE For: ______________________________ Producer:______________

The information in this questionnaire is designed to assist a medical/disability insurance carrier's evaluation of your group. Most competitive insurers are unlikely to prepare a bid unless a reasonable amount of plan claims experience information for at least the last three (3) years is provided. This form should be completed, signed and dated, and returned to your CPEhr sales representative for inclusion with all Request For Proposal (RFP) submissions.

Prospective Group Information

Total number of benefit-eligible employees:_____________

Total number of enrolled employees:______________________

Current number of COBRA continuees:_____________________

(Note eligibility completion date and description of qualifying event on page 2, under "Additional Comments.")

Portion of employee premiums paid by employer:

Portion of dependent premiums paid by employer:

Has your group been declined for coverage by any health insurance carrier in the last 12 months?

Date of Decline:____________________ Carrier:____

Describe any ineligible employee classifications:____

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents [proprietors, partners, corporate officers, employees, dependent children and spouses (include domestic partners if the prior or current plan designates them eligible)]. For all "YES" answers, please provide as much detail as possible in the grid below. If the medical condition is not listed, please describe under "OTHER." Assign a letter "A, B, C" to each individual you enter in the grid. Record additional comments on page 2.

	Yes	No	Note (if unknown, so state)
1. Have any claims over $10,000 been paid in the past twelve (12) months?			____________________________
2. Has any employee missed ten or more consecutive days of work in the past twelve (12) months due to illness or injury?			____________________________
3. Are there any ongoing medical leaves of absence/disabilities?			____________________________
4. Are any current employees or dependents pregnant? If so, what is the due date?			____________________________
5. Are you aware of any employee or dependent who has hospitalization or treatment pending or has been advised that hospitalization, surgery or treatment is needed?			____________________________
6. Have any individuals been diagnosed, received treatment, been hospitalized, or are currently receiving treatment for any of the following conditions in the past three (3) years?			____________________________
7. Are any below-identified individuals COBRA continues? If "YES," When will each individual's COBRA eligibility be complete? and What was the qualifying event? (If the individual was entered in the grid, not the assigned letter next to the response.)			____________________________

Condition	Yes / No	Mo./Yr. Diagnosed	Prognosis (Current Treatment Outlook)	Plan Option (HMO/POS)	Ee Employment Site (City & State)	Ee Dep	Age	Claim Amount
Cancers (type)								
Kidney Ailments								
Diabetes (indicate if insulin dependent)								
Heart Conditions								
Alcohol/Drug Abuse/Psych Disorders								
Liver Diseases								
Immune System Disorders								
Organ Transplants								
Lung Conditions								
Obesity (Greater than 200% of Ideal Weight								
Migraine Headaches								

Condition	Yes / No	Mo./Yr. Diagnosed	Prognosis (Current Treatment Outlook)	Plan Option (HMO/POS)	Ee Employment Site (City & State)	Ee Dep	Age	Claim Amount
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								

Additional Comments: ____

____

____

____

____

____

____

____

____

____

The Employer/Plan Sponsor acknowledges that the requested proposal(s), if issued, will be based upon the information disclosed in this questionnaire as well as upon other representations made my the Employer/Plan Sponsor. The Employer/Plan Sponsor understands that the insurance carrier(s) may adjust all quoted benefits and rates based upon any information or representations relevant to the underwriting risk, including final enrollment, minimum participation levels and Employer/Employee contributions levels.

The above statements are true to the best of my knowledge.

Signature of Employer/Plan Sponsor
Representative:___√____Date:___________________

Printed Name and Title:____

Employer/Plan Sponsor Name:____

Employer/Plan Sponsor Address (City State, Zip):____

____

Employer/Plan Sponsor Telephone:______________________________ Fax:__________________________

Company Name:

Page _____ of _____

Broker:

Employment Location (City, State, Zip):

SIC Code: __________

Yrs w current carrier: ________

Renewal Date: __________

ees on COBRA: _______

% Employer Contribution: _________

% Employee Participation: _________

No.	Employee Name (Last Name, First Name)	Status (PT/FT)	Date of Birth	Gender (M / F)	Residence Zip Code	Job Title	Annual *Compensation*	Medical Name Carrier	Med (M) Vis (V) Den (D) COBRA	Plan (POS) (HMO) (PPO) Medical	Ee (X) Only (4-Tier Med Enrollment)	Ee & (X) Spouse (4-Tier Med Enrollment)	Ee & (X) Child(ren) (4-Tier Med Enrollment)	Ee & (X) Family (4-Tier Med Enrollment)
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														