

# Small Group Qualifying Questionnaire



Information needed to prospect a new group health case

Rev. 3/24/21

Name of Prospect/Company: \_\_\_\_\_

Company Contact: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Company Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is above address the group headquarters?  Yes  No

If "no", please provide: \_\_\_\_\_

Company Phone: \_\_\_\_\_ Company Email: \_\_\_\_\_

Date the business was established: \_\_\_\_\_ Payroll start date for W2'd non-owner/spouse employee: \_\_\_\_\_

Is the company with a PEO for payroll and/or benefits?  Yes  No

If the company is on a PEO, is company leaving PEO?  Yes  No

Type of business/Industry (SIC code): \_\_\_\_\_

Business entity type:  Sole Prop  Partnership  Corporation  LLC  Other: \_\_\_\_\_

Workers' Compensation Insurance?  Yes  No

Are there any affiliated companies?  Yes  No

If "yes," are they eligible to file a joint tax return?  Yes  No

How many full-time eligible employees? \_\_\_\_\_ Part-time coverage?  Yes, How many? \_\_\_\_\_  No

Total number of full-time equivalent (FTE) employees: \_\_\_\_\_

Number of eligible employees located outside CA: \_\_\_\_\_

Number of COBRA/Cal-Cobra participants: \_\_\_\_\_ Number of employees on leave of absence: \_\_\_\_\_

All employees W2?  Yes  No

Any 1099 employees?  Yes  No

Number of eligible employees not covered on the current plan with valid waivers: \_\_\_\_\_

Employer contribution for EE: \_\_\_\_\_% or \$\_\_\_\_\_ Dependent contribution: \_\_\_\_\_% or \$\_\_\_\_\_

Current group health plan design:  HMO  PPO  No prior coverage

Likes/Dislikes about your current plan? \_\_\_\_\_

What do you currently offer?  Medical  Dental  Vision  Life  STD  LTD  Other \_\_\_\_\_

Current carrier(s) and Renewal date(s): \_\_\_\_\_

Current or Renewal rates available?  Yes  No Current billing available?  Yes  No

Current ancillary products? \_\_\_\_\_ Renewal dates? \_\_\_\_\_

Why are you shopping for new coverage? \_\_\_\_\_

Do you wish to upgrade/downgrade benefits? \_\_\_\_\_

What specific medical/dental benefits are important to you? \_\_\_\_\_