Client Questionnaire

Company Name ______________________________

First Name ______________ Last Name ______________ Job Title ______________

Address ______________________ City ______________ State ________ Zip ________

Phone ______________________ Email ______________________

Business entity type ☐ Sole Proprietor ☐ Partnership ☐ S Corporation ☐ LLC ☐ Other ______________

Is your business entity domiciled in Colorado? ☐ Yes ☐ No

Do you have an office outside of Colorado? ☐ Yes ☐ No

Do you have out-of-state employees? ☐ Yes ☐ No

Do you have Common Ownership in any other business entities? ☐ Yes ☐ No

Does the business have W2 employees other than the owner and spouse? ☐ Yes ☐ No

How many employees working 30+ hours did you have on payroll in the last 12 months? # ____________

How many employees currently on payroll work 30+ hours per week? # ____________

How many employees currently on payroll work less than 30 hours per week? # ____________

How many seasonal (less than 120 non-consecutive days per calendar year) do you have? # ____________

What is your current probationary period for a new hire to be eligible for coverage?
☐ 1st of the month following ☐ 30 days ☐ 60 days or ☐ Date of Hire ☐ 90 days / Immediately

What is the number of hours worked to be eligible? # ____________

Do you currently determine eligibility based on class of employee? ☐ Yes ☐ No

If yes, what class division do you use? (e.g., management v. non-management, hourly v. salary) ______________

Do you have terminated employees currently on COBRA /State Continuation? ☐ Yes ☐ No

Do you have any 1099 /contract employees? ☐ Yes ☐ No

How much do you contribute towards your employee's medical benefits? $ ____________ or % ____________

Payroll frequency _____ 12 (monthly) _____ 24 (semi-monthly) _____ 26 (bi-weekly) _____ 52 (weekly)

Do you contribute towards the dependent's medical benefits? ☐ Yes ☐ No $ ____________ or % ____________

Do you currently offer Ancillary coverage to your employees? (check all that apply)
☐ Dental ☐ Vision ☐ Life ☐ LTD ☐ STD ☐ Employer Paid or ☐ Voluntary

How much do you contribute towards your employee's ancillary benefits? $ ____________ or % ____________

Do you contribute towards the dependents ancillary benefits? ☐ Yes ☐ No $ ____________ or % ____________

Does the group have Medicare eligible beneficiaries? (employee and/or dependents? ☐ Yes ☐ No

Do you have a Premium Only Plan (POP) for pre-tax treatment of employee contributions? ☐ Yes ☐ No

If yes, is your plan document up to date? ☐ Yes ☐ No

Is your ERISA (SPD) plan document up to date? ☐ Yes ☐ No

Do you need a general list of Employer Model Notices? ☐ Yes ☐ No

Do you use a payroll company? ☐ Yes ☐ No If yes, which company? ______________

Are you interested in offering Ancillary coverage to your employees? (check all that apply)
☐ Dental ☐ Vision ☐ Life ☐ LTD ☐ STD ☐ Employer Paid or ☐ Voluntary

Would you like to see how adding supplemental voluntary benefits, at no cost to you, can complement your existing medical plan and help offset rising healthcare costs? ☐ Yes ☐ No

Completed by: ______________________ Date: ______________