

# Client Questionnaire

Client Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

Email Address: \_\_\_\_\_

Business Entity Type:    Sole Proprietor    Partnership    S Corporation    LLC  
Other \_\_\_\_\_

Is the business entity domiciled in Colorado?    Yes    No    Nature of Business? \_\_\_\_\_

Do you have an office outside of Colorado?    Yes    No

Are there any other business entities in which you have ownership?    Yes    No

Total number of full-time (30 hours or more per week) employees on payroll: \_\_\_\_\_

Total number of part-time (less than 30 hours per week) employees on payroll: \_\_\_\_\_

Total number of seasonal workers (working fewer than 120 non-consecutive days per calendar year)? \_\_\_\_\_

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

What is your current definition of a full-time employee based on hours worked per week?:  
\_\_\_\_\_

What is your current probationary period for a new hire to be eligible for coverage?  
0 days    30 days    60 days    90 days    Other: \_\_\_\_\_

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

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

Do you have employees located outside Colorado?    Yes    No

Do you have terminated employees currently on COBRA/State Continuation?    Yes    No  
If yes, how many? \_\_\_\_\_

Do you have any 1099/contract employees?    Yes    No    If yes, how many? \_\_\_\_\_

What is your current employer contribution for employees? \$ \_\_\_\_\_ or \_\_\_\_\_%

Payroll Frequency    12 (monthly)    24 (semi-mo)    26 (bi-weekly)    52 (weekly)

What benefit(s) are currently offered to your employees? (*check all that apply*)  
Medical    Dental    Vision    Life    LTD    STD    Voluntary    PFML

Do you contribute towards your employee's ancillary benefits?    Yes    No

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

Do you use a payroll company?    Yes    No    If yes, which company? \_\_\_\_\_

Do you fund company dollars into your employees' Health Savings Accounts or a Health Reimbursement Arrangement?    Yes    No    If yes, which company? \_\_\_\_\_

Does your group have any Medicare eligible beneficiaries?    Employee \_\_\_\_\_    Dependent \_\_\_\_\_