APPLICATION

Client Size (check one): ☐ **Individual** ☐ **Employer 2-5 employees** ☐ **Employer 6-10 employees**

Date of Application: _____ Name of Broker/Agent: _____

Desired Implementation Date: _____ Promotion Code: _____

How did you hear about us? _____

BUSINESS INFORMATION

Your Company Name: _____ dba Name: _____

Company Address: _____ City/ST/Zip: _____

Contact: _____ Telephone: _____

Email: _____ FEIN: _____

Business Type (circle one): ☐ S-Corp ☐ Sole Proprietor ☐ C-Corp ☐ Partnership ☐ LLC ☐ Other

Description of Operations: _____

CURRENT OUTSOURCED PROVIDERS

Do you currently use a Payroll Company ☐ YES ☐ NO Do you currently use a PEO? ☐ YES ☐ NO

If Yes to either answer, please provide name of Outsourced Provider: _____

Do you have Workers' Compensation Insurance ☐ YES ☐ NO

(If YES, please attach a copy of your policy)

CURRENT HEALTHCARE & BENEFITS INFORMATION

Healthcare Benefits: ☐ YES ☐ NO ☐ WAIVED Dental Insurance: ☐ YES ☐ NO ☐ WAIVED

Vision insurance: ☐ YES ☐ NO ☐ WAIVED Do You Have a 401k: ☐ YES ☐ NO

NOTES/COMMENTS: _____

If this is an application for a Sole Proprietor, please indicate desired coverage: _____

(Myself Employee/Spouse Employee/Children Family Waive)

NOTE: ALL APPLICANTS WILL NEED TO COMPLETE A PRELIMINARY HEALTH QUESTIONNAIRE

PRELIMINARY HEALTH QUESTIONNAIRE

Coverage: ☐ ***Employee*** ☐ ***Employee/Spouse*** ☐ ***Employee/Children*** ☐ ***Employee/Family*** ☐ ***Waive***

Employee Name: _____ Tel #: _____

Address: _____ Cell #: _____

City: _____ ST: _____ ZIP: _____ Email: _____

DEPENDENT INFORMATION

Employee Name	Social Security #	Gender	DOB	Zip Code	Coverage Elected
		☐ M ☐ F			☐ YES ☐ NO
Spouse name					
		☐ M ☐ F			☐ YES ☐ NO
Dependent Child(ren)					
		☐ M ☐ F			☐ YES ☐ NO
		☐ M ☐ F			☐ YES ☐ NO
		☐ M ☐ F			☐ YES ☐ NO

CURRENT HEALTHCARE & BENEFITS INFORMATION

1. In the past ***5 years***, have you been advised or had medical attention or surgical treatment for any reason? ☐ YES ☐ NO
2. Are you or any of your covered dependents currently taking prescription medications? ☐ YES ☐ NO
3. Are you or any of your dependents pregnant or disabled? ☐ YES ☐ NO
4. Ever been diagnosed as having a mental or nervous disorder, drug/alcohol problem, HIV or AIDS Complex? ☐ YES ☐ NO
5. In the past ***5 years,*** been treated for serious illness for example: cancer, Diabetes, Cardiovascular Disease? ☐ YES ☐ NO

Give full details here, if YES to any questions above. Please print and use additional sheet if necessary

Onset Date	Condition	Medication/Dosage	Recovery Date	Doctor Name & Number

I certify that the information above is true and correct to the best of my knowledge and acknowledge and agree that in the event information has been intentionally omitted or misrepresented, the application may be denied or terminated in breach.

Signature: _____

Complete, sign and email to the address below.

Once completed please email to team@yourpayrollmanager.com

Payroll Manager • Atlanta, Georgia • www.YourPayrollManager.com • P: 1-770.-609-5607