Employer Questionnaire

Business Name: ____

DBA:____

FEIN: ____

Entity Type:

□ LLC □ Corporation □ S-Corp □ Partnership □ LLP □ Sole Proprietor □ Non-Profit

Year business started: ____

Payroll Cycle: ____

Website: ____

Location Address: ____

____

Mailing Address: ____

____

Phone: ____

Fax: ____

Primary Contact:

Name: ____

Title: ____

Phone: ___________________________ Email: ____

Plan Information:

Current Carrier(s): ____

Renewal Date: ____

Current Coverage:

□ Medical □ Vision □ Other ______________________________________

□ Dental □ Life ______________________________________

Are you interested in any other coverage for your business? If yes, explain __________________

____

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