Your Company's Profile

Company Information

Name: _____

Company Address: _____

City: _____ **State:**____ **Zip:**_____

County: _____

Company Phone:(____)_____-_____**Alternate Phone:**(_____)_____-_____

Company Fax:(_____)_____-_____

Tax ID: _____ **Years in Business:** _____

Owner Name(s): _____ **Phone:**(_____)_____-_____

Owner Email(s): _____

Primary Contact Name(s) and Title: _____

Primary Contact Email(s): _____

Secondary Contact Name(s) and Title: _____

Secondary Contact Email(s): _____

Type of Entity: (circle)

Corporation C-Corp Private	Corporation C-Corp Public	Corporation S-Corp
Limited Liability Company	Limited Liability Partnership	Partnership
Sole Proprietorship	Government Entity	Non-Profit

Account Information

Hours per week to be eligible for plan(s): _____

Waiting Period (check one): ____NONE _____30 Days ____60 Days

Effective Date (check one): _____ Date of Hire
_____ First of the month after completion of waiting period

*Note: In no event may a waiting period be longer than 90 calendar days.

Rehire provisions if different than above: _____

Other Criteria: (circle) Full time Certified Salaried

# of Employees currently eligible for insurance coverage: _____

Pay Cycle (check one): _____Monthly _____Semi Monthly

_____Bi Weekly _____Weekly

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Your Company's Current Insurance Coverage(s)

Coverage(s) your company currently offers: (check all that apply)

☐ Health Company: _____ Renewal:_____ Group #: _____
☐ Life/AD&D Company: _____ Renewal:_____ Group #: _____
☐ Voluntary Life Company: _____ Renewal:_____ Group #: _____
☐ Dental Company: _____ Renewal:_____ Group #: _____
☐ STD Company: _____ Renewal:_____ Group #: _____
☐ LTD Company: _____ Renewal:_____ Group #: _____
☐ Vision Company: _____ Renewal:_____ Group #: _____
☐ Voluntary Benefits (Such as Colonial or Aflac)
Company: _____ Renewal:_____ Group #: _____
☐ Flex Benefits Company: _____ Renewal:_____ Group #: _____
☐ 401K/403B Company: _____ Renewal:_____ Group #: _____
☐ HSA Vendor: _____
☐ HRA Vendor: _____

Employer Contribution for each line of coverage ($ or %):

Health: (s)_____ (f)_____ Life/AD&D: (s)_____ (f)_____ Voluntary Life: NA
Dental: (s)_____ (f)_____ STD: (s)_____ (f)_____ Voluntary Benefits: NA
Vision: (s)_____ (f)_____ LTD: (s)_____ (f)_____ 401K/403B (match):_____

Flex Plan: _____ (circle one): annual use it or lose it $500 carryover 3 month carryover

Coverage(s) your company would like more information about: (check all that apply)

☐ Health ☐ Dental ☐ Vision
☐ Life/AD&D ☐ Short Term Disability
☐ Voluntary Life ☐ Long Term Disability

COBRA / MN Continuation

Do you currently have any previous employees on COBRA/MN Continuation or within their election period? ☐ **Yes** ☐ **No**

If yes, please include name, address and coverage information on additional sheet

Your Companies Logo

Please check the option that applies:
☐ Yes, we have a logo in .jpeg form that I can email to Primary Benefit Services.
☐ No, we do not have a logo at this time.

Effective date of AOR (Agent of Record): _____/_____/_____