

Peach State Planning

Company Information Form

EMPLOYER INFORMATION

LEGAL COMPANY NAME _____

TYPE OF BUSINESS _____

BUSINESS ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

CONTACT PERSON _____

EMPLOYEE INFORMATION

TOTAL NUMBER OF FULL TIME EMPLOYEES _____ (25 hours or more)

NUMBER OF EMPLOYEES ENROLLING FOR HEALTH INSURANCE _____

NUMBER OF EMPLOYEES COVERED ELSEWHERE _____

NUMBER OF EMPLOYEES COVERED UNDER COBRA (if eligible) _____

EMPLOYER PAYS WHAT PERCENTAGE OF PREMIUM _____ % Employee _____ % Dependents

CURRENT BENEFITS

(Please complete as much information as possible)

Medical

Check one _____ PPO _____ HMO _____ POS _____ INDEMNITY _____

Deductible _____

Co-Insurance Percentage(100%, 90%, 80%) _____

Maximum individual out-of-pocket _____

Waiting Period for New Employees _____

Maternity _____ Yes _____ No _____

Prescription Card _____ Generic _____
Preferred Brand Formulary _____
Non-Preferred Formulary _____

Current Carrier _____ How Long? _____ Renewal Date _____

Requested Plan Changes

Dental

Current Carrier _____

What percent does plan pay for Preventive _____ Basic _____ Major _____

Deductible _____ Calendar Year Maximum _____

Disability

Current Carrier _____

Current Rates (Provide the most recent bill or list below)

	Medical	Dental
Employee Only	_____	_____
Employee & Spouse	_____	_____
Employee & Children Only	_____	_____
Family(Employee, Spouse & Children)	_____	_____