JB GROSS INSURANCE AGENCY LLC

GROUP CONTACT SHEET

TODAY'S DATE:_____ **REFERRED BY:**_____

PROPOSED EFFECTIVE DATE:_____

COMPANY NAME:_____ **DBA:**_____

CONTACT:_____ **PHONE 1:**_____

ADDRESS:_____ **PHONE 2:**_____

_____ **FAX:**_____

E-MAIL:_____ **WEBSITE:**_____

ADDITIONAL LOCATIONS:_____

NATURE OF BUSINESS:_____ **SIC/NAIC CODE:**_____

BUSINESS TYPE: ☐ CORPORATION ☐ PARTNERSHIP ☐ SOLE PROPRIETOR ☐ OTHER_____

SECT 125: ☐ YES/ ☐ NO **HRA:** ☐ YES/ ☐ NO **HSA:** ☐ YES/ ☐ NO **TEFRA:** ☐ YES/ ☐ NO

TWC REPORT: ☐ YES/ ☐ NO **TIN#:**_____ **PEO:** ☐ YES/ ☐ NO

HOW MANY ELIGIBLE EMPLOYEES? _____ **NUMBER OF YEARS IN BUSINESS:**_____

W-2 TOTAL:_____ **FULL TIME:**_____ **PART TIME:**_____ **SEASONAL:**_____

PAYROLL FREQUENCY: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI MONTHLY ☐ MONTHLY

AVERAGE NUMBER OF EMPLOYEES*:_____

*To calculate the annual average number of employees, add all the monthly employee totals together, then divide by the number of months you were in business last year. (Usually 12 months)

CURRENT INSURANCE CARRIER:_____ **EMPLOYER CONTRIBUTION:**_____

WAITING PERIOD: ☐ 0 DAYS ☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS (Not Medical)

EMPLOYEE'S ON COBRA: ☐ YES/ ☐ NO **LIST NAMES:**_____

WORKER'S COMPENSATION COVERAGE: ☐ YES/ ☐ NO **CARRIER'S NAME:**_____

☐ **MEDICAL:** *DEDUCTIBLES*_____ *COINSURANCE*_____

☐HMO ☐PPO ☐HSA ☐HRA ☐DRUG CARD ☐COPAY

CURRENT MEDICAL: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%**

☐ **DENTAL:**

☐ DHMO ☐ PPO ☐ORTHO ☐DUAL OPTION ☐VOLUNTARY ☐EMPLOYER PAID

CURRENT DENTAL: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%** ☐Voluntary ☐Rollover Benefits

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☐ **DISABILITY:**

☐ STD: Waiting Period _____ % of salary _____ to Age _____ Elimination Period _____

Benefit Period _____ ☐Voluntary ☐Employer Paid

☐ LTD: Waiting Period _____ % of salary _____ to Age _____ Elimination Period _____

Benefit Period _____ ☐Voluntary ☐Employer Paid

CURRENT DISABILITY: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%** ☐Voluntary ☐Employer Paid

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☐ **LIFE:** ☐FLAT AMOUNT_____ ☐VOLUNTARY ☐EMPLOYER PAID

☐SUPPLEMENTAL EE LIFE ☐SUPPLEMENTAL DEP LIFE

CURRENT LIFE: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%** ☐Voluntary ☐Employer Paid

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☐ **VISION:** ☐VOLUNTARY ☐ EMPLOYER PAID

CURRENT VISION: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%** ☐Voluntary ☐Employer Paid

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☐ **OTHER:**_____ ☐VOLUNTARY ☐EMPLOYER PAID

CURRENT OTHER: Carrier Name_____ Length of Coverage_____

Contribution: EE_____**%** DEP_____**%** ☐Voluntary ☐Employer Paid

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PROVIDER NAME	PROVIDER TYPE	PHONE NUMBER	CITY, STATE
1			
2			
3			
4			
5			
6			
7			
8			

SIGNATURE OF GROUP CONTACT SUBMITTING BOTH PAGES: _____