Small Group Qualifying Questionnaire

Information needed to prospect a new group health case

Rev. 3/24/21

Name of Prospect/Company:______________________________

Company Contact:______________________________ Effective Date:______________

Company Address:______________________________ State:________ Zip Code: __________

Is above address the group headquarters? ☐ Yes ☐ No

If "no", please provide:______________________________

Company Phone:______________ Company Email:______________________________

Date the business was established:________ Payroll start date for W2'd non-owner/spouse employee: ________

Is the company with a PEO for payroll and/or benefits? ☐ Yes ☐ No

If the company is on a PEO, is company leaving PEO? ☐ Yes ☐ No

Type of business/Industry (SIC code):______________

Business entity type: ☐ Sole Prop ☐ Partnership ☐ Corporation ☐ LLC ☐ Other:______________

Workers' Compensation Insurance? ☐ Yes ☐ No

Are there any affiliated companies? ☐ Yes ☐ No

If "yes," are they eligible to file a joint tax return? ☐ Yes ☐ No

How many full-time eligible employees?________ Part-time coverage? ☐ Yes, How many?________ ☐ No

Total number of full-time equivalent (FTE) employees: ________

Number of eligible employees located outside CA: ________

Number of COBRA/Cal-Cobra participants: ________ Number of employees on leave of absence: ________

All employees W2? ☐ Yes ☐ No

Any 1099 employees? ☐ Yes ☐ No

Number of eligible employees not covered on the current plan with valid waivers: ________

Employer contribution for EE: ________% or $________ Dependent contribution: ________% or $________

Current group health plan design: ☐ HMO ☐ PPO ☐ No prior coverage

Likes/Dislikes about your current plan?______________________________

What do you currently offer? ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ STD ☐ LTD ☐ Other______________

Current carrier(s) and Renewal date(s):______________________________

Current or Renewal rates available? ☐ Yes ☐ No Current billing available? ☐ Yes ☐ No

Current ancillary products?______________ Renewal dates?______________

Why are you shopping for new coverage?______________________________

Do you wish to upgrade/downgrade benefits?______________________________

What specific medical/dental benefits are important to you?______________________________