



Coverage Effective Date _____

PEO Questionnaire (page 1 of 4)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. Decision HR will not accept the questionnaire if incomplete.

Date _____

Proposed Effective Date: _____

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
Company Name					
Street Address					
City		State		Zip	
County		Benefits Contact & Phone #			
Total Number of employees on payroll:		Total Full Time:		Total Number of employees currently enrolled in health care plan:	
		Total Part Time:			
Current Health Carrier:	Health Carrier Renewal Date: ____ / ____ / ____				
Years with Current Carrier:	Renewal Rates Received? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is Claims Experience available for your group? <input type="checkbox"/> Yes (provide reports) <input type="checkbox"/> No					
Is your current Plan Self-Funded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know ***If yes, please provide claims.					
Are you currently with a PEO? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of PEO:	Does your Company currently have a Wellness Program in place? <input type="checkbox"/> Yes (attach details) <input type="checkbox"/> No				
Please provide a description of your business operation:	Does your Company currently have a Smoking or Tobacco Cessation program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Number of Locations: _____	Please identify all states of operation: _____				
Are any health plan enrollees NOT paid employees (other than spouses or children)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

A. List any current COBRA / State Continuation participants: NONE

Name / DOB / Phone # of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date: NONE

Name / DOB / Phone # of Individual	Date Eligible	Activating Event/Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. CURRENT HEALTH PLAN EMPLOYER CONTRIBUTION INFORMATION <i>(Does your company have more than one Contribution Level? If so, please list each separately)</i>				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (\$ or %)				
Company Contribution Levels (\$ or %)				

III. RATE HISTORY & PLAN DESIGN DETAILS (include the 3 most elected plans)				
Plan 1 Name: _____	# Enrolled _____	Renewal Rates (eff. ___/___/___)	Current Rates (eff. ___/___/___)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
<i>Enrollment</i>		<i>Premium Rates or Total Premiums</i>		<i>Plan Design Details</i>
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out-of-Pocket Max\$ _____ (excluding ded.)
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs ___/___/___

Plan 2 Name: _____	# Enrolled _____	Renewal Rates (eff. ___/___/___)	Current Rates (eff. ___/___/___)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
<i>Enrollment</i>		<i>Premium Rates or Total Premiums</i>		<i>Plan Design Details</i>
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out-of-Pocket Max\$ _____ (excluding ded.)
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs ___/___/___

Plan 3 Name: _____	# Enrolled _____	Renewal Rates (eff. ___/___/___)	Current Rates (eff. ___/___/___)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
<i>Enrollment</i>		<i>Premium Rates or Total Premiums</i>		<i>Plan Design Details</i>
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out-of-Pocket Max\$ _____ (excluding ded.)
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs ___/___/___

- Attach a copy of your benefit & billing summary for each plan and year listed above.
- Include carrier claims report if available.

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Next, please answer the following questions on behalf of your company to the best of your knowledge. This information will help determine if your group is best served by the implementation of a wellness program, as part of the Affordable Care Act.

IV. WELLNESS PROGRAM IMPACT APPRAISAL																									
A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?						To the Best of My Knowledge <input type="checkbox"/> YES <input type="checkbox"/> NO																			
B. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?						<input type="checkbox"/> YES <input type="checkbox"/> NO																			
C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?						<input type="checkbox"/> YES <input type="checkbox"/> NO																			
<i>(If yes to any, please provide details in the table below.)</i>																									
D. If anyone is currently being treated or been advised to seek treatment for any of the following, please check all that apply:																									
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AIDS or testing HIV Positive</td> <td><input type="checkbox"/> kidney disorder</td> <td><input type="checkbox"/> stroke</td> </tr> <tr> <td><input type="checkbox"/> arthritis</td> <td><input type="checkbox"/> liver disease</td> <td><input type="checkbox"/> substance dependency</td> </tr> <tr> <td><input type="checkbox"/> back disorder</td> <td><input type="checkbox"/> mental illness</td> <td><input type="checkbox"/> transplants</td> </tr> <tr> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> muscular disorder</td> <td><input type="checkbox"/> tumor</td> </tr> <tr> <td><input type="checkbox"/> diabetes</td> <td><input type="checkbox"/> nervous system disorder</td> <td><input type="checkbox"/> other serious conditions</td> </tr> <tr> <td><input type="checkbox"/> heart disease</td> <td><input type="checkbox"/> respiratory disease</td> <td></td> </tr> </table>								<input type="checkbox"/> AIDS or testing HIV Positive	<input type="checkbox"/> kidney disorder	<input type="checkbox"/> stroke	<input type="checkbox"/> arthritis	<input type="checkbox"/> liver disease	<input type="checkbox"/> substance dependency	<input type="checkbox"/> back disorder	<input type="checkbox"/> mental illness	<input type="checkbox"/> transplants	<input type="checkbox"/> cancer	<input type="checkbox"/> muscular disorder	<input type="checkbox"/> tumor	<input type="checkbox"/> diabetes	<input type="checkbox"/> nervous system disorder	<input type="checkbox"/> other serious conditions	<input type="checkbox"/> heart disease	<input type="checkbox"/> respiratory disease	
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<input type="checkbox"/> heart disease	<input type="checkbox"/> respiratory disease																								
<i>(For all checked boxes, please provide details below)</i>																									
Name (Optional)	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery																		

C. List any employees and/or dependents who are on the health plan that are disabled:

NONE

Name	Disability	Qualifying Event

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Is Anyone Currently Pregnant? If yes, please provide due date and note below if normal, high risk, multiple birth, or preterm labor with this pregnancy. <i>This includes employees, dependents or COBRA participants.</i>		To the Best of My Knowledge: <input type="checkbox"/> YES <input type="checkbox"/> NO
Name (Optional)	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

The undersigned attests that the information is true and correct to the best of their knowledge. Authorization is provided to Decision HR to verify any of the information herein. The undersigned confirms that this is a Request for Proposal. This is not a contract for service with Decision HR. Any service provided will require a separate contract of service.

Authorized Signature

Title

Date

Print Name

Print Name of Company

Broker / Sales Signature

Broker / Sales Print Name

Date