



FIRST SOURCE
benefits group

Group Benefits Fact Finder

Date of Interview: _____ Effective Date of Coverage: _____

Company Name: _____

H.O. Address: _____ City: _____ State: _____ Zip: _____ County: _____

Contact Name: _____ Phone: _____ Fax: _____

Mobile: _____ Email: _____

Nature of Business: _____

Multiple Locations? Yes No (if yes, please indicate the full address of each location)

Address 1: _____ City: _____ State: _____ Zip: _____ County: _____

Address 2: _____ City: _____ State: _____ Zip: _____ County: _____

Address 3: _____ City: _____ State: _____ Zip: _____ County: _____

Years in Business: _____

Total # Employees: _____ # of Full-Time: _____ # of Part-Time: _____ # on Current Plan: _____ # Waiving: _____

of Union: _____ Are they covered under a separate Union contract? Yes No

Is this administered under a local payroll company? Yes No # of Pay Periods per year: _____

Do the employees share in the premium? Yes No If yes, what percent: _____

Are you a Chamber of Commerce Member? Yes No If yes, what Chamber Alliance: _____

Do you currently have a Section 125 Plan? Yes No

Do you currently have a 401(k) Plan? Yes No

Current Medical Carrier: _____ Plan Type/Name: _____

Current Medical Deductible: _____ Office Copay: _____ Drug Card Copay: _____ IP Copay: _____ OP Copay: _____

Coinsurance: _____ to _____

