



**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 \_\_\_\_\_

