EMI HEALTH

Group and Plan Information

Group Information	
Group Name:	**Desired Effective Date:**
Address:	**City / ZIP / County:**
Phone:	**SIC Code / Nature of Business:**
Years in Business:	**Fed Tax ID:**
Total # of Eligible Employees:	**% Participation:**
Number of EE's residing Out of Area:	**% Turn Over:**
Location(s) with zip-code:	**Number of COBRA Enrollees:**
Current Health Carrier:	**How long?**
Waiting Period:	**Previous Carriers (5 years):**
Employer Contribution (Medical): Employee	**Dependent**
Employer Contribution(Dental): Employee	**Dependent**

Medical Rates and Plan Information					
Plan 1	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**	**Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)**
Renewal					
Current					
Prior					
Plan 2	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**	**Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)**
Renewal					
Current					
Prior					
Plan 3	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**	**Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)**
Renewal					
Current					
Prior					

Health & Wellness Initiatives	**Date of Last Health Fair:**		**Years In Place:**	

Dental Rates and Plan Information					
Plan 1	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**	**Description**
Renewal					
Current					
Prior					
Plan 2	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**	**Description**
Renewal					
Current					
Prior					

Additional Information
Client Notes: (Please share any additional information that you would like the underwriter to know)