CHARLES NEWMANCO.
INSURANCE — EMPLOYEE BENEFITS

PEO Request for Proposal

In addition to the questions in this form, you must provide the following:

- Payroll Register
- Workers Compensation declaration page
- Medical plan invoice, plan design and last renewal
- Current employee census
- Claims experience (*if available)*
- Group Health Questionnaire

General Information

Name of Company				Tax ID Number	
DBA					
Address					
City		State		Zip Code	
Owner Contact				Email	
HR Contact				Email	
Phone				URL	
States of Operation				Years in Business	
Industry					
Corporation type					
Subsidiaries with EIN					

Human Resources / IT Details

	Yes	No	Details
Are independent contractors on payroll?			*how many?*
Liability coverage for current employment?			*cost & amount?*
Current payroll provider			
Current property/casualty insurance provider			
HRIS/HRIM System in place?			*cost?*
Is an employee assistance program offered?			*cost?*
Are employee background checks performed?			*cost?*
Is an employee handbook provided?			*if yes, last update*
Is a time management recording system used?			*specify system*
G/L interface required?			*specify system*
Other IT requirements?			

Current Benefits Offered / Requested

	Yes	No	Quote		Yes	No	Quote
Dental / Vision				Health Insurance			
PEO/ASO/HRO				Long Term Care			
Life/Key Man				Directors & Officers			
LTD / STD				Errors & Omissions			
Retirement (401K)				General Liability			
Executive Comp				Home/Auto Protection			

Payroll Information

Conversion Contact Person		Phone	Email
Payroll Frequency			
Annual Gross Payroll		Full Time Ees	Part Time Ees
State Unemployment Rate (SUTA)			
Number of Payroll Delivery Locations		Languages Spoken	
Direct Deposit Required?		Certified Payroll Required?	
Payroll Week End Day		Call-in Day	Delivery Day
Current Method of Submission		Time import, Time Sheet, Web?	
Special Job Reports Required?		Specify if Yes	

Retirement Benefits

	Yes	No	
Current section 125?			
Type of Plan	❑Premium Only ❑Dependent ❑ Medical		
Current 401(k) Plan:			
Intent to adopt providers 401(k):			
Name of Provider			
Cost	$		
Employer Match			*how much?*
Safe Harbor Plan?			
Profit Sharing Plan?			
403B?			

Additional Information

	Yes	No			Yes	No	
Written safety program?			*provide copy*	Are Vehicles Used for Company Business:			
OSHA inspection / citation			*provide copy*	Vehicles Company-owned:			
OSHA 300 Log				Work Performed Under Wrap or Owner Controlled Insurance Program:			
Work performed underground or above 15 ft?				Out of State Travel:			*which states?*
Work performed on barges, vessels, docks, bridges over water?				Drug-Free Workplace Program:			*provide copy*
Subcontractors employed?				Drug-testing Policy:	❑Pre-Employment ❑ Random ❑ Post-Accident ❑ Reasonable Suspicion		
Certification verification program?				Work From Home Options:			
Group Transportation Used				Are There Any Intentions to Enter into Contract with Federal Entities:			
Safety Equipment Used:							
Any Coverage Cancelled/declined in the past 3 years:							

Current Overall Costs / Budget			
Please Specify Amounts Spent for This Year			
Payroll		Employee Assistance Program	
Employee Related Legal Issues		401(k) Administration	
UC Claim Management		Background Checks	
Risk Management		COBRA Management	
HRMS System		Employee Training/Development	
Time Clock System		Tax Filing Costs	

Customer Acknowledgement

I represent that all answers and statements on this form are complete and true to the best of my knowledge. I further understand that omissions, misrepresentations, or misstatements may result in termination of the service agreement. I understand that medical coverage will be made effective based on these statements.

_____ _____ _____

Authorized Customer Representative | Title | Date

CHARLES NEWMANCO.
INSURANCE — EMPLOYEE BENEFITS

BENEFITS UNDERWRITING QUESTIONNAIRE

Company Name: _____

1. Number of Full-Time EE's:_____ Number Eligible for Health Coverage: _____ Number of Participants: _____

2. Current Insurance Carrier or PEO: _____ Eff. Date: _____ Renewal Date: _____

3. Type of Coverage (please circle): HMO POS PPO HDHP

4. Please indicate your current and renewal rates below (*if this is not your renewal period, include last year's rates instead*):

Current Rates: Employee $ _____ EE+SP $_____ EE+CH $ _____Family $ _____

Renewal Rates: Employee $ _____ EE+SP $_____ EE+CH $ _____Family $ _____

5. Please answer the following questions to the best of your knowledge. *Please do not disclose the name of any employee or dependent*. Give details to "yes" answers below. Use additional sheets if necessary.

	YES	NO
a) Are any employees or dependents currently pregnant? If yes, what trimester?		
b) Are any of the employees currently disabled, hospitalized or not actively at work?		
c) Did any employee, dependent or COBRA participants incur over $5,000 in claims in the last 12 months?		
d) Do any employees or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary?		
e) Has the company received a Decline to Quote from any carrier or PEO in the past 3 years?		
f) Have any employees, dependents of COBRA participants been diagnosed or treated for the following conditions:		

	Cancer (last 5 yrs)		Blood Disorders		Stomach Disorder		Psychological
	Alcohol / Drug abuse		Heart Condition		Back Problems		Multiple Sclerosis
	Muscular Dystrophy		Diabetes		AIDS		Other

If you answered 'YES' to any of the above questions, please explain in detail below:

Name of Condition Date of Diagnosis Treatment/Medication

_____

_____

_____

6. Do you have any COBRA enrollees? _____ (if yes please list below)

Employee Name Date of Event Coverage Level & Plan Type

_____

_____

7. Do any employees reside in another state or region? _____ (if yes please list below)

I undersigned hereby certifies that the information in this Medical Questionnaire is correct. In the event that information has been omitted, the insurance carrier may deny or limit coverage for an employee. I certify that all answers and statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind any insurance coverage.

PROSPECTIVE CLIENT

Signature:_____ Date:_____