Small Group Medical Intake Form

Business Name _____ **Date** _____

Contact Person _____

Phone _____

Address _____

City, State _____ **Zip** _____

Email _____

What is your company structure?

O S-Corporation O C-Corporation O Partnership O Sole Proprietor' O LLC
O Non-profit O Other _____

What is your Federal Employee Identification Number (FEIN) ? _____

If you do not have an FEIN, what is your tax ID? _____

How many employees total? _____ **What is your industry?** _____

Do you know your SIC code? _____

Please note, medical insurance must be offered to all full-time, eligible employees. 65% participation is required to qualify.

Do you currently offer medical insurance? _____

If yes, which carrier do you use? _____

What prodcuts are you interested in offering? _____

How did you hear about us? _____

Any additional information you would like to provide us? _____

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