ZINN INSURANCE

Group Client Business Information Sheet

Name of Company:_____

Contact Person of Group_____

Phone_____ Cell #:_____Fax:_____

Email:_____

Physical Address: _____

City_____ State: _____ Zip Code: _____

Address 2:_____

Tax ID: _____Nature of Business/ SIC Code:_____

When Estab.? /Yrs in Bus. _____ Referred By: _____

Prior Benefits: _____ Renewal Month: _____ Payroll Provider: _____

Prior

Total # of Employees: _____
Full Time Emp: _____
Part-Time Emp: _____
Cobra Participation: _____
Covered Elsewhere: _____
In waiting Pd: _____
Number to be quoted: _____

Current Medical Carrier: _____
Current Benefits:_____
_____
Employee Carve Out: yes/ no
Employer Contribution:
Employee: _____% or $_____
Dependent: _____% or $_____

Current

Total # of Employees: _____
Full Time Emp: _____
Part-Time Emp: _____
Cobra Participation: _____
Covered Elsewhere: _____
In waiting Pd: _____
Number to be quoted: _____

Current Medical Carrier: _____
Current Benefits:_____
_____
Employee Carve Out: yes/ no
Employer Contribution:
Employee: _____% or $_____
Dependent: _____% or $_____

Comments:_____
_____
_____
_____
_____
_____

Thank You!!