




# PEO Advantage

## PEO Request for Proposal

In addition this form, please provide the following:

-  Payroll Register
-  Current medical plan description, invoice & last renewal
-  Current employee census

### 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?			<i>how many?</i>
Liability coverage for current employment?			<i>cost &amp; amount?</i>
Current payroll provider			
Current property/casualty insurance provider			
HRIS/HRIM System in place?			<i>cost?</i>
Is an employee assistance program offered?			<i>cost?</i>
Are employee background checks performed?			<i>cost?</i>
Is an employee handbook provided?			<i>if yes, last update</i>
Is a time management recording system used?			<i>specify system</i>
G/L interface required?			<i>specify system</i>
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	<input type="checkbox"/> Premium Only <input type="checkbox"/> Dependent <input type="checkbox"/> Medical		
Current 401(k) Plan:			
Intent to adopt providers 401(k):			
Name of Provider			
Cost	\$		
Employer Match			<i>how much?</i>
Safe Harbor Plan?			
Profit Sharing Plan?			
403B?			

## Additional Information

	Yes	No			Yes	No	
Written safety program?			<i>provide copy</i>	Are Vehicles Used for Company Business:			
OSHA inspection / citation			<i>provide copy</i>	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:			<i>which states?</i>
Work performed on barges, vessels, docks, bridges over water?				Drug-Free Workplace Program:			<i>provide copy</i>
Subcontractors employed?				Drug-testing Policy:	<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Post-Accident <input type="checkbox"/> 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

# 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?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are any of the employees currently disabled, hospitalized or not actively at work?	<input type="checkbox"/>	<input type="checkbox"/>
c) Did any employee, dependent or COBRA participants incur over \$5,000 in claims in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
d) Do any employees or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary?	<input type="checkbox"/>	<input type="checkbox"/>
e) Has the company received a Decline to Quote from any carrier or PEO in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
f) Have any employees, dependents of COBRA participants been diagnosed or treated for the following conditions:	<input type="checkbox"/>	<input type="checkbox"/>

	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:** \_\_\_\_\_