EMI HEALTH
Smart Benefits

Group and Plan Information

Group Information	
Group Name:	Desired Effective Date:
Address:	City / ZIP/ County:
Phone:	Nature of Business:
Years in Business:	Fed Tax ID:
Total # of Full - time 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?
Employer Contribution (Medical): Employee	Dependent
Employer Contribution(Dental): Employee	Dependent
Waiting Period:	Previous Carriers (5 years):

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)