PEO Request for Proposal

Client and company information

Requested Effective Date | Client Legal Name | DBA

Client Company Contact | Title

Locations — please attach a list with all location addresses

Phone | Fax | Email

FT Employees | # PT Employees | # Contract Employees | # Locations | # of Entities

FEIN # | Nature of Business | SIC Code

PAYROLL & RISK

Weekly | Bi-weekly | Semi-monthly | Monthly | Gross Annual Pay

Current payroll provider and annual cost, if outsourced

State unemployment rate(s) | EPLI annual cost (if applicable)

Employment attorney / HR outsourcing — annual cost (if applicable)

Outsourced services annual cost (COBRA, unemployment claims management, HR collateral, HR or WC trainings, etc.)

BENEFITS REQUESTED — PLEASE CHECK ALL THAT APPLY

	Health	Dental	Life	LTD	STD	401(k) Plan
Benefits Requested	☐	☐	☐	☐	☐	☐
Employer Contribution Towards	☐	☐	☐	☐	☐	☐

DOCUMENTATION REQUIRED FOR PROPOSAL (FOR EACH STATE OF OPERATION)

- ☐ Last 4 quarters state unemployment return (summary page only) or NJ-927 in NJ
- ☐ Three years workers' compensation loss runs
- ☐ Census information
- ☐ If 100+ people on healthcare: medical loss runs (or last renewal and upcoming renewal with claims information)
- ☐ For NY groups: copy of DBL bill
- ☐ Copy of workers' compensation declaration page(s), including detail of payroll by WC class, modifier, and any applicable premiums, discounts or surcharges
- ☐ Recent healthcare billing, explanation of coverage, renewal (if applicable)
- ☐ Health questionnaire — groups with fewer than 25 employees enrolled on benefits may be required to complete an individual medical questionnaire
- ☐ If the client is with an existing PEO: most recent invoice and a description of benefits with current renewal dates

Group Health Questionnaire

Please answer the following questions on behalf of your company to the best of your knowledge. You may include additional sheets for detailed explanations.

SERIOUS ILLNESS / CONDITION QUESTIONS — TO THE BEST OF YOUR KNOWLEDGE

	Yes	No
A. Has employee, dependent, or COBRA participant incurred over $5,000 in claims in the last 12 months?	☐	☐
B. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, or incapable of self-support because of physical or mental disability?	☐	☐
C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	☐	☐
D. Has the company received a Decline to Quote by any carrier or PEO in the past 3 years?	☐	☐

E. CURRENTLY BEING TREATED, OR ADVISED TO SEEK TREATMENT, FOR ANY OF THE FOLLOWING?

Please check all that apply.

- ☐ AIDS or testing HIV positive
- ☐ Arthritis
- ☐ Back disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disorder
- ☐ Liver disease
- ☐ Mental illness
- ☐ Muscular disorder
- ☐ Nervous system disorders
- ☐ Respiratory disease
- ☐ Stroke
- ☐ Substance dependency
- ☐ Transplants
- ☐ Tumor
- ☐ Other serious conditions
- ☐ Alcohol / drug abuse
- ☐ Blood disorder
- ☐ Stomach disorder
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy

FOR ALL CHECKED BOXES, PLEASE PROVIDE DETAILS BELOW

M/F	Age	Condition	Date of Onset	Last Treated	Treatment / Drug	Degree of Recovery

COBRA / State Continuation

List any current COBRA / State Continuation participants: ☐ NONE

Name / DOB / Phone # of Individual	Effective Date	Activating Event / Date

List any participants currently eligible for COBRA who have not yet elected coverage, and/or any participants who will become eligible for COBRA prior to the Health Plan effective date: ☐ NONE

Name / DOB / Phone # of Individual	Effective Date	Activating Event / Date

PREGNANCY

Is anyone currently pregnant? If yes, please provide the due date and note below if normal, high-risk, multiple birth, or preterm labor. This includes employees, dependents, or COBRA participants.

Due Date	Type of Pregnancy or Condition (normal, high-risk, preterm labor, etc.)

The information gathered is for actuarial use only and is not used in connection with any decisions or actions regarding any individual's employment. Because actuarial analysis requires current, accurate information, this questionnaire expires 60 days from the date signed below; after that time, a new questionnaire will be required.

I certify that the statements above are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

Authorized Signature	Title	Date

Print Name	Name of Company