



**Company Information**

**Company Name:** \_\_\_\_\_

**Company Contact:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Company Address:** \_\_\_\_\_

**Company EIN:** \_\_\_\_\_

**Has your company been in business longer than a year?**  **Yes**  **No**

**Insurance Information**

*Please tell us about your current coverage to help us create a full picture of your company's current offerings and needs.*

**Medical Insurance**

**Does your company currently offer Medical insurance?**  **Yes**  **No**

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

**Current Deductible:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Does your company contribute toward insurance costs?**  **Yes**  **No**

*If yes, please indicate the contribution amount and whether it applies to employees only or dependents as well.*

**Company Contribution:** \_\_\_\_\_

**Do you have a current Summary of Benefits?**  **Yes**  **No**

*If you have a current Summary of Benefits, feel free to attach it with this completed form. This allows us to review your existing coverage*

**Would you like to see quotes on this type of insurance?**  **Yes**  **No**





**Dental Insurance**

Does your company currently offer Dental insurance?  Yes  No

Carrier: \_\_\_\_\_

Current Deductible: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Does your company contribute toward insurance costs?  Yes  No

*If yes, please indicate the contribution amount and whether it applies to employees only or dependents as well.*

Company Contribution: \_\_\_\_\_

Do you have a current Summary of Benefits?  Yes  No

*If you have a current Summary of Benefits, feel free to attach it with this completed form. This allows us to review your existing coverage*

Would you like to see quotes on this type of insurance?  Yes  No

**Vision Insurance**

Does your company currently offer Vision insurance?  Yes  No

Carrier: \_\_\_\_\_

Current Deductible: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Does your company contribute toward insurance costs?  Yes  No

*If yes, please indicate the contribution amount and whether it applies to employees only or dependents as well.*

Company Contribution: \_\_\_\_\_

Do you have a current Summary of Benefits?  Yes  No

*If you have a current Summary of Benefits, feel free to attach it with this completed form. This allows us to review your existing coverage*

Would you like to see quotes on this type of insurance?  Yes  No



**Life / Short-Term Disability (STD) / Long-Term Disability (LTD) Insurance**

Does your company currently offer Life / STD / LTD insurance?  Yes  No

Carrier: \_\_\_\_\_

Current Deductible: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Does your company contribute toward insurance costs?  Yes  No

*If yes, please indicate the contribution amount and whether it applies to employees only or dependents as well.*

Company Contribution: \_\_\_\_\_

Do you have a current Summary of Benefits?  Yes  No

*If you have a current Summary of Benefits, feel free to attach it with this completed form. This allows us to review your existing coverage*

Would you like to see quotes on this type of insurance?  Yes  No

**Other Ancillary Insurance**

Does your company currently offer other ancillary insurance?  Yes  No

What type? \_\_\_\_\_ Carrier: \_\_\_\_\_

Current Deductible: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Does your company contribute toward insurance costs?  Yes  No

*If yes, please indicate the contribution amount and whether it applies to employees only or dependents as well.*

Company Contribution: \_\_\_\_\_

Do you have a current Summary of Benefits?  Yes  No

*If you have a current Summary of Benefits, feel free to attach it with this completed form. This allows us to review your existing coverage*

Would you like to see quotes on this type of insurance?  Yes  No



**Coverage Preferences & Goals**

*If you have any goals or preferences, it's helpful for us to know.  
Please answer these few quick preferences and provide any additional notes.*

**Coverage Priority:**

- Keep costs low (affordable premiums)**
- Balance cost and coverage (moderate premiums with solid benefits)**
- Premium Coverage (comprehensive benefits)**

**Health Savings Account (HSA) Preference:**

- Must Have**    **Nice to Have**    **No Preference**

**List Any Other Preferences:**

*Full family coverage, dental & vision, telehealth/virtual care, low deductible plans, etc.*

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**Current Employee Information**

*We need information for all anticipated enrolling employees and their dependents.*

**To save time, please attach a current Employee Census.**

**If you do not have a current census, you can download our YBIH Spreadsheet from [here](#).**

**PLEASE complete it with the information for all enrolling employees and their dependents.**

