

HOLT & JOHNSON INSURANCE AGENCY

**105 Madison Ave.
Fredericksburg, VA 22405**

GROUP INSURANCE CENSUS FORM

Company Name: _____
Company Contact: _____ Type of Business _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Email: _____

Please list ALL employees who are eligible for health care benefits (work more than 30 hours) and are not already covered on another group plan (usually through their spouse). Use a second sheet if necessary.

HOLT & JOHNSON INSURANCE AGENCY

Return this form by fax or email to: **Attention: Becky Paytes**
Fax: 540-370-1999
Phone: 540-370-4243
Email: beckypaytes@aol.com

| EMPLOYEE | | | | DEPENDENTS | | |
|----------|---------------|-----|------------------|--------------|------------------|--------------------|
| | Employee Name | M/F | Birthdate or Age | Spouse (Y/N) | Birthdate or Age | Number of Children |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
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| 17 | | | | | | |
| 18 | | | | | | |
| 19 | | | | | | |
| 20 | | | | | | |

(If any employees reside out of state please provide their home zip code)

Interested in dental: (Y/N?) _____ \$1000 or _____ \$1500 maximum yearly benefit.
Interested in vision? (Y/N?) _____
Interested in life insurance? (Y/N?) _____

Interested in short/long term disability insurance? (Y/N)_____

(If yes, please complete the following page regarding specific job title/description & salary so that I may provide you a quote)

Company Taxpayer Type?

C-Corp___ S-Corp___ LLC___ LLP___ Partnership___ Sole Prop___

Please indicate officers or owners of the company.

| EMPLOYEE | | | | Census Information For Short/Long Term Disability | | |
|----------|---------------|-----|------------------|---|-------------|-------------------|
| | Employee Name | M/F | Birthdate or Age | Job Title | Description | Salary (per year) |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
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| 20 | | | | | | |

Confidential Group Health Insurance Field Underwriting Questionnaire

Our approach is to become more intimate with your unique Group Health Insurance needs in order to address your concerns and streamline the bidding process. We appreciate your valuable time for answering each of the questions below and sincerely look forward to serving you and building a long-term relationship. Thank you very much.

1. Please complete the attached census and provide the following information for your existing plan(s):
2. Briefly explain any concerns or frustrations your group may be experiencing with your current carrier(s), insurance plan(s), brokerage firm or other.
3. Summarize your company's goals, objectives and expectations for this exercise.

4. Provide the following information for your existing plan(s):

| Coverage Type | Carrier Name 1 | Plan Name 1 | Carrier Name 2 | Plan Name 2 | Renewal Date 1 | Renewal Date 2 | Mo. Prem. Carrier 1 | Mo. Prem. Carrier 2 |
|-----------------------|----------------|-------------|----------------|-------------|----------------|----------------|---------------------|---------------------|
| Medical | | | | | | | | |
| Dental | | | | | | | | |
| Life | | | | | | | | |
| Vision | | | | | | | | |
| Short Term Disability | | | | | | | | |
| Long Term Disability | | | | | | | | |
| 401(K) | | | | | | | | |

5. In order to manage the cost of your benefits program, would you like to: (Choose Letter(s) _____)
 - a. Learn about "Consumer Driven Plans"
 - i. Health Savings Accounts
 - ii. Health Reimbursement Accounts
 - b. Learn about "Employer Defined Contribution" programs
 - c. Learn about "Minimum Premium Funding"

6. In designing your medical insurance plan, mark "XXX" your preference from the following options:

| | | | | | |
|------------|-------|-------|-------|--------|-------|
| Dr. Co pay | \$10 | \$15 | \$20 | \$25 | Other |
| Deductible | \$250 | \$500 | \$750 | \$1000 | Other |

7. In designing your medical insurance program, would you like to: (Choose Letter) _____
 - a. Offer PPO only
 - b. Offer HMO only
 - c. Offer a combination of HMO *and* PPO plan options
8. If employees contribute to their premiums or they pay for their dependent costs, are these premiums paid on a (a) Pre-tax or (b) Post-tax basis? (Choose Letter) _____