New Case
Information Checklist

Sales and Marketing Phone: (302) 629-8570 Fax: (302) 629-2566

1. Company Name: ______________________
   Address: ______________________
   City, State, Zip: ______________________

2. Contact Person Name: ______________________
   Telephone: (   ) ______________________

3. Renewal Anniversary Date: ______________________

4. Number of years company has been in business: ________

5. Nature of company's business: ______________________

   ____

6. Other company locations with zip codes: ______________________

   ____

7. Current Health Insurance Carrier: ______________________
   Number of Carriers in the past 5 years: ________

8. Type of Plan: PPN ____ PPO ____ HMO____ Other ________

9. Health Plan Rates:

	Prior Year	Current Year	Renewal Year
Employee:	$	$	$
Employee/Spouse:	$	$	$
Employee/Child(ren):	$	$	$
Family:	$	$	$

10. Other Benefits Currently in Force: Dental ____ Vision ____
    Life and AD&D ____ Section 125 ____ WDI ____

11. Major on-going claims to include alcohol/drug abuse, cancer, cardiovascular disease, chronic renal failure, diabetes, HIV, or mental/nervous conditions:

    ____

    ____

    ____

12. Employee census to include Name, DOB, Sex, Coverage and all COBRA participants (with start date).

13. Copy of current Employee Health Plan.

(attach additional pages as necessary)

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