

## Business Information Survey

GENERAL COMPANY INFORMATION			
Business Legal Name:		DBA:	
Address:			
City:		State:	Zip:
Owner Name:		% ownership:	Phone:
Fax:		Email address:	
Additional owner(s) name(s):		% ownership:	Phone:
Fax:		Email address:	
All other business addresses:			
Cities:		States:	Zips:
FEIN:	Date Incorporated:	State of incorporation:	# of years in business:
Form of business:	<input type="checkbox"/> S Corp <input type="checkbox"/> C Corp <input type="checkbox"/> LLC <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Nonprofit (type): <input type="checkbox"/> Other:		
NAICS or SIC Code:	Business description:		
Current SUTA rate: %	I am interested in the following business model: <input type="checkbox"/> PEO <input type="checkbox"/> ASO <input type="checkbox"/> Undetermined <i>Note: Mid-year conversions may require more lead time.</i>		

HUMAN RESOURCES	
Who is currently handling your human resource functions? <input type="checkbox"/> FT employee(s) <input type="checkbox"/> PT employee(s) <input type="checkbox"/> PEO (name): <input type="checkbox"/> Other:	
We anticipate needing HR on-site: <input type="checkbox"/> 3+ days/week <input type="checkbox"/> 1-2 days/week <input type="checkbox"/> 1-2 times/month <input type="checkbox"/> Less than once a month	
Do you have any collective bargaining agreements in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any employment agreements or contracts in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- ✓ Submit:**
- Any collective bargaining agreements currently in place
  - Any employment agreements or contracts currently in place
  - If currently with another PEO, submit current PEO bill

BENEFITS					
What benefits do you currently offer your employees and what benefits are you interested in receiving information about? (Check all that apply.)					
	Currently offer	Information needed		Currently offer	Information needed
Medical			401K		
Dental			Flexible spending		
Vision			Employee Assistance Program (EAP)		
Short-term disability			Wellness program		
Long-term disability			Other:		
Life insurance			Other:		
# hours needed to work to qualify for benefits:			# of EEs currently eligible for benefits:		
Eligibility criteria (include definition of full-time):					
Type(s) of plans offered: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP			Renewal date:		
Anticipated rate change: %		# of carriers in last 5 years:			
Employer contribution (\$ or %):		Executive:	Management:	Employee:	
Copay:		Deductible:		Co-insurance:	

- Submit:**
- Current medical, dental, life, disability and 401K benefit plan descriptions
  - Most recent premium bills, rates and contribution rules for all offered benefit plans

PAYROLL		
Amount of gross payroll per month:	Amount of fees currently paying (monthly) for payroll services: \$	
First pay period begins:	First pay period ends:	First pay date:
Pay Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:		

- Submit:**
- Current payroll register
  - Most recent Quarterly Wage and Tax Statement
  - Note employees hired, terminated or changed since last statement

RISK MANAGEMENT	
Current Workers' Comp Modifier:	Workers' Comp codes used:

Break down Workers' Compensation information by state and class code.

State	Class Code	# Full-Time EEs	# Part-Time EEs	Total Wages

List unemployment account numbers by state and give current rate.

State	Unemployment Account #	Current Tax Rate

Give a detailed description of operations and employee job duties:

*If you answer yes to any of the questions below, please give details in the following 'remarks' section.*

	Y	N		Y	N
Are any EEs currently exempt from WC coverage?			Are subcontractors used? <i>If yes, give percent, type and location of work subcontracted below.</i>		
Do you have any employees under 16 or over 60 years of age?			Are you engaged in any other type of business?		
Are you a federal contractor?			Any work subcontracted without certificates of WC insurance?		
Are there any CDL/DOT licensed drivers?			Is group transportation provided?		
Do you have a drug-free workplace conducting pre-employment drug testing?			Is a formal safety program in place? <i>If yes, please provide a summary below.</i>		
If not, are you willing to become one?			Is there volunteer or donated labor?		
Is there a light duty return-to-work program for injured employees?			Any employees travel out of state for an extended period of time?		
If not, are you willing to implement one?			Have you filed or intend to file for Chapter 7 or 11 protection?		
Do you own, operate or lease air or water craft?			Is there any other insurance with current WC insurer?		
Do past/present/discontinued operations involve storing, treating, discharging, applying, disposing or transporting hazardous materials?			Has prior coverage been declined, canceled or non-renewed in the last three years?		
Any work performed on barges, vessels, docks or bridges over water?			Do any employees predominately work at home? If so, how many?		
Any work performed underground or above 15 feet?			Any seasonal employees? If so, how many?		

**Remarks:**


**Submit:**

- Workers' compensation loss runs for the past three years
- Workers' compensation premium bill
- Most recent SUTA rate notification
- Annual payroll broken down by WC class code

# Employee Census

	Employee Name	Job Title	Employment Date	FT/PT Seasonal	WC Class	Annual Earnings	Home Zip	Sex	DOB	Eligible for medical (Y/N)	Coverage (E, ES, EC, FAM)	EE ID	Life only	Cobra Cont.
	<i>Example</i>	<i>President</i>	<i>10/01/1980</i>	<i>FT</i>	<i>8810</i>	<i>\$500,000</i>	<i>60523</i>	<i>M</i>	<i>01/11/1958</i>	<i>Y</i>	<i>FAM</i>	<i>111-11-1111</i>		
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**✓Submit:**

Census (use chart above or submit existing report)

