

Health & Welfare Benefits Audit Request

Company Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
E-Mail: _____

Nature of Business: _____
SIC Code: _____

Plan Information:

(Circle at the apply)

	<u>Yes/No</u>	<u>Current Carrier</u>	<u>Renewal Dates:</u>
Medical Plan	Y N	_____	_____
Dental Plan	Y N	_____	_____
Life Insurance	Y N	_____	_____
Short Term Disability	Y N	_____	_____
Long Term Disability	Y N	_____	_____
Voluntary Plans	Y N	_____	_____
401k/Profit Sharing	Y N	_____	_____
Section 125 Plan	Y N	_____	_____

Employee Contributions for Benefit Plans:

(Per Month)

Medical: _____ % or \$ _____
Dental: _____ % or \$ _____
Life Insurance: _____ % or \$ _____
Short Term Disability: _____ % or \$ _____
Long Term Disability: _____ % or \$ _____

Please complete the following:

Number of Full Time Employees: _____
Number on Insurance Plans: _____
Number of Part Time Employees: _____
Number of COBRA / Continuation Participants: _____

Please fax back with census to (860) 348-9144 or mail to: Corporate Insurance Solutions, 450 Main Street, Suite 203, New Britain CT 06051