

**Employer Data Form**

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

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail \_\_\_\_\_

- Industry: \_\_\_\_\_
- Employer Contribution: \_\_\_\_\_ Time In Business \_\_\_\_\_
- Multi-Location Employees: \_\_\_\_\_ On census indicate city, state and zip.
- Class Carve: Yes\_\_ No\_\_ (Type: Mgt.\_\_ Hourly\_\_ Salary\_\_ Occ.\_\_)
- Are All Eligible Employees on AZ Unemployment Tax and Wage: Yes\_\_ No\_\_
  1. If "No" They must be Owners, Officers, Partners , Members or Eligible Contracted 1099 Employees.

**Current Group Carrier:**

Medical: \_\_\_\_\_ Length of time: \_\_\_\_\_

Dental: \_\_\_\_\_ Length of time: \_\_\_\_\_

Life: \_\_\_\_\_ Length of time: \_\_\_\_\_

Vision: \_\_\_\_\_ Length of time: \_\_\_\_\_

Disability: \_\_\_\_\_ Length of time: \_\_\_\_\_

**No Current Benefits:** \_\_\_\_\_

**Preferred Benefits:**

Medical: PPO (with Co pays)		HDHP (with H.S.A)			
Deductible: \$500	\$1000	\$1500	\$2500	\$3500	\$5000
Co-Insurance: 100%	90%/70%	80%/60%	70%/50%		

**Ancillary Benefits**

**Voluntary or Employer Paid – Circle Requested Benefit**

Dental DHMO      PPO    Indemnity

Vision

Life

Disability Short Term

Disability Long Term

Work Site Program

P.O.P 125 or Flex Benefits

Health statements will be required for all groups between 2-26 enrolled employees.

**Lookout Mountain Insurance Group, LLC**

**Mert Bean 602-843-3670**

**Fax 1-866-886-6990**

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