LIC # 0D80851
3315 Old Conejo Road, Thousand Oaks, CA 91320
PHONE: 888.501.2747 (CSIS) FAX: 888.502.2747 (CSIS)
WWW.CSISONLINE.COM

GROUP HEALTH INSURANCE INFORMATION

How did you hear about us?

❒ BIA ❒ Chamber of Commerce ❒ Current Client ❒ Email
❒ Google ❒ Mailer ❒ Yahoo ❒ Yellow pages
❒ Referral: _____ ❒ Website: _____

Named insured _____

Owner's name _____ Contact's name _____

Phone #: _____ Cell # _____ Fax # _____

Email: _____ Preferred method of contact: ❒ Phone ❒ Fax ❒ Email ❒ Mail

Mailing address: _____

Physical/Premise address _____

Business entity: ❒ Sole proprietorship ❒ Partnership ❒ Corporation ❒ LLC ❒ Other: _____

Do you carry Workers' Compensation insurance? _____ Carrier Name: _____

Group Information:

Group Name: _____ Requested Effective Date: _____

Nature of Business: _____ SIC Code: _____

Length of time in business: _____

Desired Co-payment: _____ What is your monthly budget range? _____

Current Carrier/Plan Type: _____

Do you prefer a specific carrier? _____

Are you interested in any additional coverages: ❑ Dental ❑ Vision ❑ Life ❑ Maternity

Are you interested in quotes from: ❑ PPO ❑ HMO ❑ Both

What is the objective to shopping? Upgrade/downgrade benefits? Save money? _____

What are your likes/dislikes about your current plan? _____

What specific benefits are important to you? _____

Please provide a copy of your current bill and ID card, if applicable.

THIS IS NOT AN APPLICATION, IT IS ONLY A PRELIMINARY INFO SHEET FOR A QUOTE.
ADDITIONAL INFORMATION MAY BE REQUIRED.

Employee & Dependent Information:

Number of full time employees (30+ hours/week): _____ Part time: _____

Are any employees declining or waiving coverage? How many? _____

Will coverage be offered to Part Time employees? _____

Employer Contribution for employee (minimum 50% or $100 for employee) _____% OR $ _____

Employer Contribution for dependents? _____% OR $ _____

Is there a waiting period for employee benefits? How long? _____

Census Information: Please attach a second page if more room is needed
(If you have this information on a separate sheet you match attach that instead of completing this page.)

***Coverage Needed: E = Employee Only, ES = Employee & Spouse Only, EC = Employee & Children Only, FF = Full Family**

Full Name	Male or Female?	Date of Birth?	Spouse DOB	# of Children	Children DOB	Home Zip Code	Coverage Needed*

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