

Benefit Survey for CHHSM Agencies
Revision Date 10/1/07

1. Company Name: _____

2. Contact Person: _____

3. Contact Information:

Voice: _____

Fax _____

Email _____

4. Number of Employees: _____

5. Number of Employees enrolled for medical coverage: _____

6. Dental coverage: _____

7. Benefit Plan Anniversary Date: _____

8. Medical Carrier: _____

9. Dental Carrier: _____

10. TPA Vendor: _____

11. Type of Coverage: Self-Funded Fully-Insured

12. Do you provide the following benefit programs to your employees

Yes -- Flexible Spending Account

Yes -- Long Term Disability

Yes -- Pension/IRA contributions

Yes -- Health Reimbursement Account/Health Savings Account

13. Company serving as Broker: _____

14. Copy of Schedule of Benefits of plan(s) provided

Medical Copy of Schedule of Benefits of plan(s) provided

Dental Copy of Schedule of Benefits of plan(s) provided

Medical Billing Statement Received

Dental Billing Statement Received

15. Rate History by rate tiers

Current Year:

Single _____

Two Adults _____

EE + Child(ren) _____

EE + Family _____

One year ago:

Single _____

Two Adults _____

EE + Child(ren) _____

EE + Family _____

Two years ago:

Single _____
Two Adults _____
EE + Child(ren) _____
EE + Family _____

16. Do you offer COBRA coverage for terminating employees Yes No

17. If you outsource COBRA activity, who is the vendor? _____

18. Seeking Enrollmt in next 12 months

19. Seeking Enrollmt Next year

20. Unknown Target Enmt date

Completed by: _____

Date: _____