

Premium Only Plan Questionnaire



Employer Information

Employer Company Name

Employer EIN

Employer Organization Type

Corporation, Limited Liability Company, Partnership, S Corporation, Sole Proprietorship, Non-Profit Organization, Estate, Professional Corporation, Governmental Entity or Church

Employer Organization State

Employer Primary Contact Information

Contact Name (First & Last)

Address

Address

City

State

Zip

Phone Number

Email Address

Affiliates (if applicable)

An affiliate generally means:

- Subsidiaries which are owned (at least 80% ownership) by the plan sponsor
- Other companies which are owned (at least 80% ownership) by a parent company which also owns 80% of the plan

Document Information

Would you like to add a custom appendix item to the table of contents? (if unsure YES / NO choose no)

POP Questionnaire

Plan Information

Is this Plan new or a restatement?	New / Restatement
If this is a brand new plan for your company, please select "New." If you are amending and restating a previous plan, please select "Restatement"	
Plan Year Start	mm/dd/yyyy
The Plan Year Start should be consistent with the plan year for all other group benefits if possible. Do not back date a plan year start.	
Plan Year End	mm/dd/yyyy
The date on which this Plan Year ends - typically the end of the calendar year or the end of the 12th month after the Plan Year Start - with the exception of short plan years.	
Original Effective Date (only if Restatement)	mm/dd/yyyy
Amended and Restated Date (only if Restatement)	mm/dd/yyyy
Short Plan Year	YES / NO
Renewal Year Start (only if short Plan year)	mm/dd/yyyy
State the date on which the Plan year that follows the short plan year will start.	
Renewal Year End (only if short Plan year)	mm/dd/yyyy
State the date on which the Plan year that follows the short plan year will end.	

POP Questionnaire

Plan Benefits

Does your plan offer the following benefits? (YES / NO)

Group Medical Insurance	Long-Term Disability Insurance
Group Dental Insurance	Short-Term Disability Insurance
Group Vision Insurance	Accidental Death and Dismemberment Insurance
HSA Contributions	Critical Illness Insurance
Group Term Life	Hospital Indemnity Insurance
Cancer Insurance	Cash In Lieu of Benefits
Voluntary Benefits	Intensive Care Insurance
Personal Sickness Indemnity	Specified Health Event

Elections and Plan Options

Employee Elections	Election Required First Year Only / Election Required Each Plan Year / No Election Required, May Opt-Out
Include Participant Election Forms	YES / NO
Allow Change of Status if employee Full-Time status drops below 30 hours?	YES / NO
Allow Change of Status if employee is eligible for a Special Enrollment or Annual Open Enrollment Period in a qualified Health Plan within a Marketplace?	YES / NO
Allow a Change in Status in the middle of the plan year if an employee's dependent is eligible for a Special Enrollment to enroll in a Qualified Health Plan within a state or federal Exchange?	YES / NO
Include FMLA Language?	YES / NO