

THE CAMPBELL GROUP

PEO Survey

Sales Rep: _____ Date: _____

Underwriter: _____

Organization: _____

Contact: (Mr, Mrs, Ms, or Miss) _____

CFO: (Mr, Mrs, Ms, or Miss) _____

Payroll Contact: (Mr, Mrs, Ms, or Miss) _____

Employee Benefits Contact: (Mr, Mrs, Ms, or Miss) _____

Mailing Address: _____ City/State/Zip: _____ County: _____

Physical Address: _____ City/State/Zip: _____ County: _____

Phone: _____ Fax: _____ E-Mail: _____ Website: _____

PAYROLL INFORMATION FEDERAL ID # - _____ DOT # - _____

State	Unemployment Rate	Work/Comp Class Code	Description	941 Payroll Per Class	Work Comp Rates	# of Employees By Class	Seasonal
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	_____	_____	Y / N

Experience Modifier: _____ Scheduled Credit: _____

Surcharge: _____ Premium Discount: _____

Name of W.C. Carrier: _____ Other Credits: _____

Expiration Date: _____ ***5 Years Loss Information must be supplied.**

Pay Cycle: (circle one) Weekly Bi Weekly Other

ADDITIONAL DATA

Year Business Established _____

Approximate Annual Cost to Process Payroll/File Taxes? _____

Annual Single Business Tax? _____

How many W2s did you issue in 2002? _____

Are layoffs planned in the next 12 months? _____

Are seasonal layoffs planned? _____

If you pay Per Diem, what rate? _____

Type (Sole Prop, S-Corp, LLC, PC, LLP, Corp, Partnership): _____

Other Employment Taxes

You Pay in Your State(s): _____

City: _____

Comments Unemployment (i.e. special rates, classes, etc.): _____

CURRENT BENEFIT PLAN INFORMATION

All questions must be answered completely before underwriting can begin.

Please circle yes or no to the following. If yes, complete below:

Health Insurance Plan #1: Y/N
Name of Plan #1: _____
Plan or Group #: _____
Renewal Date: _____
Waiting Period: _____
Deductible: _____
Co-Insurance: _____
Office Visit Co-Pay: _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2 Person** Premium: _____
Monthly **Family** Premium: _____

Health Insurance Plan #2: Y/N
Name of Plan #2: _____
Plan or Group #: _____
Renewal Date: _____
Waiting Period: _____
Deductible: _____
Co-Insurance: _____
Office Visit Co-Pay: _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2 Person** Premium: _____
Monthly **Family** Premium: _____

Health Enrollment
Number of **Single**: _____
Number of **2 Person**: _____
Number of **Family**: _____

Health Enrollment
Number of **Single**: _____
Number of **2 Person**: _____
Number of **Family**: _____

Prescription
Deductible: _____
Co-Insurance: _____
Rx Co-Pay: _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2-Person** Premium: _____
Monthly **Family** Premium: _____

Prescription
Deductible: _____
Co-Insurance: _____
Rx Co-Pay: _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2-Person** Premium: _____
Monthly **Family** Premium: _____

Dental Plan: Y / N
If Yes, Name of Plan: _____
Deductible: _____
Co-Insurance: _____
Annual Maximum: _____
Orthodontia Included? _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2 Person** Premium: _____
Monthly **Family** Premium: _____

Vision Plan: Y / N
If Yes, Name of Plan: _____
% Employer Paid: _____
Monthly **Single** Premium: _____
Monthly **2 Person** Premium: _____
Monthly **Family** Premium: _____

Life Insurance: Y / N
If Yes, Name of Plan: _____
Volume: _____
Monthly Prem Per \$1,000: _____

Short Term Disability: Y / N
Long Term Disability: Y / N
AFLAC: Y / N
Cafeteria: Y / N
Reimbursement Accts: Y / N
Direct Deposit: Y / N
Profit Sharing/Pension: Y / N
Union: Y / N

Comments: _____

DISCLOSURE STATEMENT

Group:		Requested Effective Date:	
City:	State:	Zip:	

SECTION 1.

As an underwriting consideration material to the acceptance of risk, the prospective client is required to disclose the following pertinent information regarding all known individuals in the categories listed below;

Yes	No	
		Have any covered person/s had claims exceeding \$10,000 during the last 24 months.
		Are there any person/s with on-going medical conditions
		Have there been any Person/s who have been confined to a hospital or other institutions within the past 6 months.
		Are there any person/s currently pre-certified for any future hospital confinement, surgery or other treatment?
		Are there any dependent children over the normal termination age who are being continued under a disabled or handicapped extension provision.
		Are there any employees absent from work, for any reason, as of the date of this disclosure.
		Are there any former employees covered by COBRA or beneficiaries of employees covered by COBRA?
		Are there any retirees currently covered by the any sponsored medical plan?
		Disabled spouses or dependents <i>still</i> covered by the Plan

SECTION 2.

Name	Date of Birth	EE or DEP	Sex	Date of Disability	Nature of Disability	Describe Current Treatment* and Provide Estimate of Expenses in Next 12 Months	Expected Date for Return	Benefits Paid last 12 Months

*E.g. in hospital, will go to hospital, had surgery, will have surgery, major expenses to come, recovering expenses expected. Use reverse side for more space if necessary.

This information shall be treated as confidential by the Underwriters. The Plan Sponsor signed below, through its authorized person hereby warrants and represents what is complete and accurate to the best of his/her knowledge and belief, and that nothing has been knowingly or intentionally omitted. The Plan Sponsor further acknowledges, understands and agrees that this information may be used in evaluating and determining the acceptability of the Plan Sponsor's risk and that no coverage shall become effective until specifically agreed to in writing by the Underwriters.

PLEASE ANSWER SECTION 1 YES OR NO TO THE BEST OF YOUR KNOWLEDGE. IF ANY QUESTIONS ARE ANSWERED YES, PLEASE COMPLETE SECTION 2 COMPLETELY. PLEASE SIGN AND DATE BELOW.

Signature of AUTHORIZED PERSON: _____ Date: _____

Worker's Compensation – General Information

Description of Operations:

Subscriber Profile

(Provide details for all "Yes" answers)

	Yes	No
Does applicant own, operate, or lease aircraft/watercraft?		
Any past, present, or discontinued operations which involve exposure to chemicals, painting, or hazardous materials?		
Any work performed under, on or above water?		
Any work which may be subject to Jones Act, USL&H, or FELA?		
Any work performed underground or higher than 15 feet above ground level?		
Is applicant involved in any business other than that specified in the description of operations?		
Does employee turnover exceed 30% annually?		
Are any employees: Short-term lease? Temporary? Seasonal? Volunteer or donated labor?		
Any employees under age 16?		
Any employees over age 60?		
Do employees travel out of state or out of the country? If so, scope of travel?		
Are any athletic teams sponsored?		
Any group travel, ride-share programs, or tool or vehicle allowance provided?		
Are physicals required after offers of employment are made?		
Does the radius of operations vehicles exceed 200 miles?		
Are MVRs checked on all drivers?		
Is a "managed care" provider utilized?		
Is a written safety program in place? (Attach copy.) If Program in place, what is the Safety Meeting Schedule?		
Is a drug testing program in effect? (Attach copy.)		
Is an early return/light duty program in place? Does applicant "Full Pay" during periods of disability or reduced work?		
Are any subcontractors utilized? Are all subcontractors and their employees insured for workers compensation? Does applicant keep copies of their certificates of insurance? (Please provide classes and payrolls for all uninsured subcontractors and note that these uninsured subcontractors will be charged premium at the same rate as direct employees.)		
Any prior coverage declined, canceled or non-renewed in the past three (3) years?		
What percentage of employees are enrolled in a group health plan?		

Signature: _____