Hibbs ♦ Hallmark & Company
501 Shelley Drive ♦ Tyler, TX 75701
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Marketing Questionnaire and Census information

Completing this form in detail is essential and will enable the best proposal results for ***Your Specific Business.***

Referred by _____ Date _____ EB Producer _____

Employer (Full Business Name): _____

Owners Name _____

Any Common Ownership? ☐Yes ☐No if applicable, please furnish details _____

Physical Address and County _____

Mailing address (if different from Physical address) _____

Home Phone _____ Work Phone _____ Email _____

Entity Type ☐LLC ☐Inc. ☐Non Profit Date Business Started _____

Nature of Business _____

Tax ID # and SIC/ NAICS code _____

Multiple Locations? ☐Yes ☐No Multi State? ☐Yes ☐No

Insurance Coordinator _____ Title _____ Contact Preference ☐email ☐fax ☐phone

- ✓ **Proposal for Medical w/Dental, Vision & ER Paid Life** (*Additional Options upon request: Short/Long term) Disability*
- ✓ **Medical Benefits requested: Fully Funded Proposals provided**. (*Upon Request and with claims History: Level / Self-Funded Proposals available)*

Please advise if over 50% of Employees insurance premium paid by Employer (Note: Minimum of 50% Required by LAW)
PLEASE PROVIDE CURRENT SCHEDULE OF BENEFITS OR COVERAGE INFORMATION INCLUDING: CURRENT CARRIER NAME/ DEDUCTIBLE/ COINSURANCE/ COPAYS AND FURNISH MEDICAL HISTORY FOR PAST 3 YEARS (VIA HB 2015 FROM PRIOR CARRIER)

Requested Month for Coverage Effective date: _____

Do you currently have a FSA, HRA, etc.? ☐Yes ☐No If so, which one _____

Section 125? ☐Yes ☐No Name of COBRA Administrator if applicable _____

Total Employed on Payroll _____ Total Number of Full Time Employees _____

Number of Covered: Employees _____ Family _____ Spouses _____ Child (ren) _____

Total PT/Part time Employees _____ Total S/Seasonal _____

WP/New hires in waiting period	**OC**/Waive has other Covg.	**W**/Waive Has No Other Covg.	**C**/COBRA (20+)	**SC**/State Continuation (-20)
_____	_____	_____	_____	_____

Large Group Quotes ONLY (Over 50 FTE): FF ☐ LF ☐ SF ☐

EMPLOYEES

Example: If Dependent coverage desired, please list information as shown

1	**Doe, John**	M	1/1/60	75701	EF*
1B	**Doe, Spouse**	F	1/1/60	75701	
1C	**Doe, Dependent Child**	M	1/1/82	75701	

* E= Employee Only S= Covered Spouse C= Covered Child F=Covered Family

** Required

Employee Census and Covered Dependent Info: (Note: Please include COBRA Participants and show if Part Time, Seasonal, New Hire or in WP)

Employee #/First/Last Name**	Gender**	Date of Birth mm/dd/yy**	Zip code & State	Coverage Tier*

* The following Information is Necessary ONLY when quoting SHORT TERM or LONG TERM DISABILITY

Employee #/First/Last Name	Job Description & Salary Required

We value the confidence you have shown by furnishing the requested information. We are committed to protecting your personal information against unauthorized use or disclosure. Our privacy practices and data protection policies and practices are designed to comply with applicable law and to maintain your protection and trust.

- ***Derella Ann Miller*** (aka D'Ann), AAI, LPRT
  Licensed Life & Health Counselor, Asst. Vice President

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