GROUP INFORMATION FORM

Please confirm the following information

GROUP# GROUP NAME Anniversary April 1, 2017

Please complete all questions. If a question does not apply, mark N/A.

Average number of full and part-time employees over the prior calendar year (include all locations and subsidiaries) _____

If the average number of employees listed above is less than 110, what is the average number who worked at least 50% of business days during the prior calendar year. _____

Total number of current employees eligible for Dean Health Plan insurance _____

Total waiving for other creditable coverage not offered by the employer (such as spousal coverage or Medicare) _____

List Employer monthly premium contribution

Employee _____ Employee + child(ren) _____

Employee + spouse _____ Family _____

If you have more than one carrier, do you contribute the same for each plan offered? (yes/no)
If no, please explain you contribution strategy. _____

If you offer your employees a choice of other carriers, have the other carriers changed? (yes/no)

List all health insurance plans offered to employees eligible for Dean Health Plan

Name of Health Insurance Carrier	# of Insured Employees	Single Rate	Emp/Sp Rate	Emp/Ch Rate	Family Rate	Pre-ex	Deductible, Copay, Rx
		$	$	$	$	Yes/No	
		$	$	$	$	Yes/No	
		$	$	$	$	Yes/No	
		$	$	$	$	Yes/No	

Contact Person _____

Title _____

Phone _____

Please return this page to:

ACCOUNT MANAGER
Account Manager
Dean Health Plan
Direct: XXX-XXX-XXXX
Fax: XXX-XXX-XXXX
E-Mail: account.manager@deancare.com