



Complete the following for FormFire group health insurance prescreen setup. Return completed form via fax: (513) 891-3088 or email: mike@mccarthystevenot.com

Employer Name: _____

Tax ID#: _____ SIC Code: _____

Group Contact Name: _____

Group Contact Phone: _____

Group Contact Email: _____

Primary Street Address: _____

City: _____ State: _____ ZIP: _____

County: _____ Pay Periods (Check One): 52 26 24

Number of full time employees working a minimum of 30 hours: _____

Number of part time and seasonal employees: _____

Did you employ less than 50 total employees during the preceding year? Yes No

Do you have any affiliate companies/subsidiaries? Yes No

Do you have a current medical carrier? Yes No

Prior medical coverage (All plans in the last five years): _____

Is your company part of a PEO/Employee Leasing Agreement, Healthcare Alliance or Association?

Yes No

Do you (the employer) fund more than 50% of the member deductible, out-of-pocket costs (e.g., copays or coinsurance), or any bank account to fund those costs for the members covered under your plan?

Yes No

Is your company currently enrolled in a self-funded (ASO) or level-funded arrangement?

Yes No

If you are currently ASO, we will also need claims experience, large claimant listing, breakdown of fee/claim components, fully insured equivalent rates, etc.