Company Information

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Legal Company Name *(as stated on tax return)* | | | | |  | | | | | | |
| DBA Name *(as stated on tax return)* | | | | |  | | | | | | |
| Street Address: | | |  | | | | | | | | |
| City: |  | | | | State: |  | | | ZIP Code: | |  |
| Contact Name: | | |  | | | | | Contact Phone No.: | |  | |
| Website: | |  | | | | | | | | | |
| Year Established: | | | |  | No. of Locations: | |  | | | | |
| I was an Insperity client/prospect before? | | | | | Yes  No (If **Yes**, when and under what name) | | | | | | |
| Related to another Insperity client/prospect? | | | | | Yes  No (If **Yes**, describe relationship) | | | | | | |
| Recently in a PEO relationship? | | | | | Yes  No (If **Yes**, what PEO and time frame) | | | | | | |

|  |  |
| --- | --- |
| **Owner Information** | **Will Be On Insperity Payroll** |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Is/Does Your Company** | **Related Company Name** | **Percentage of Ownership** | **No. Of Employees** |
| A subsidiary or affiliate of another company?  Yes  No |  |  |  |
|  |  |  |
|  |  |  |
| Wholly or partially own other companies?  Yes  No |  |  |  |
|  |  |  |
|  |  |  |
| File consolidated or combined tax returns with other companies?  Yes  No |  |  |  |
|  |  |  |
|  |  |  |
| Do your owners have an ownership interest in other companies?  Yes  No |  |  |  |
|  |  |  |
|  |  |  |

Group Health Plan Information

|  |  |  |
| --- | --- | --- |
| Group Health Insurance currently in effect? | Yes  No | Waiting period |
| Current Carrier | From | Renewal Date |
| Prior Carrier | From | To |

Workers’ Compensation Information

|  |  |  |
| --- | --- | --- |
| Workers’ Compensation Insurance currently in effect? | Yes  No | |
| Current Carrier | From | Renewal Date |
| Prior Carrier | From | To |

Operational Information

|  |  |  |
| --- | --- | --- |
| Description of Business - *(Describe the products that you manufacture, the services you provide or sell, the warehouse or shop facilities utilized in your business and the extent to which your employees provide services at offsite locations (e.g. service delivery, product installation))* | | |
| SIC/Industry |  | |
| Is your company currently (or expected to be) an “applicable large employer” under the Affordable Care Act? \*\*  \*\* Defined as an employer that employed 50 or more full-time employees (including full-time equivalent employees) in the prior calendar year. If you have related companies (as described on page 1), include employees from all related entities in this determination. | | Yes  No  Not Sure  **(If Yes, Group Health History Questionnaire Required)** |
| Do you have former employees enrolled under (or currently in an election period for) federal or state continuation coverage? | | Yes  No  Federal COBRA No. of Former Employees  State Continuation No. of Former Employees |
| Do more than 5% of your employees work offshore, work in foreign countries or travel to foreign countries on business? | | Yes  No (If **Yes**, provide details) |
| Has your company (or any subsidiary or affiliate) ever been in bankruptcy or receivership? | | Yes  No (If **Yes**, provide details) |

I represent that all answers and statements I have provided are complete and true to the best of my knowledge and belief, including but not limited to the following:

* Information on this form including employee census data
* Health insurance information, such as summary plan descriptions, invoices and/or renewal information
* Workers’ compensation schedule of operations

|  |  |  |
| --- | --- | --- |
| Authorized Client Representative Signature | | Date Signed |
|  | |  |
| Printed Name | Title | |
|  |  | |
| Insperity Representative Signature | | Date Signed |
|  | |  |
| Printed Name | Title | |
|  |  | |

**The information on this form is considered valid and accurate for 90 days from the date the Client Representative completes, signs and dates. After 90 days and/or if any changes occur, the Client Representative must update, initial and re-date the form.**

Insperity Use Only

|  |  |
| --- | --- |
| Benefit Package |  |

Employee Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  | Status |  | Wage Type | Pay | | Pay Freq. | Coverage  Level |  |
| No. | Employee Name | Home ZIP | Age | Gender | Group No. | Job Title | Workers’ Comp. Code | Work State | **F**ull  **P**art | Avg. Hours Per Week | **S**alary  **H**ourly  **C**omm | Pay Amount | Per  **H**our **W**eek **M**onth **Y**ear | **W**eekly **B**iweekly **S**emimonth **M**onthly | **E**mployee **S**pouse **C**hild  **K** Children **F**amily **W**aived **I**neligible | Coverage Group(s)/ Option(s) |
| x | John Doe | 77339 | 36 | M | 001 | Sales Consultant | 8742 | TX | F | 40 | S | 2500 | M | S | F |  |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 9 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |