(SRA) STRATEGY REVIEW APPLICATION

General Business Information

Legal Entity Name:	**Legal Entity Type:**	**Website:**
Contact Name:	**Title:**	**Phone:**
Company Address:		**Fax:**
City:	**State:**	**ZIP Code:**
FEIN #:	**Industry:**	**Year(s) in Business:**
Payroll or PEO Provider:	**# of Locations:**	**Multiple Entities:** ☐**YES** ☐**NO,** If yes, Provide list of FEIN's Addresses and Percentages of Ownership on Page 2 of this SRA.
Payroll Cycle: **# of Full Time:**	**# of Part Time employees:**	
Non-Profit: ☐**YES** ☐**NO**	**Union:** ☐**YES** ☐**NO,** if Yes, Union:	**Annual Gross Wages:**

Employee Benefits Underwriting Questionnaire

Please answer the following to the best of your knowledge, Answer the following questions for all full-time employees, dependents, and COBRA participants. Please do not disclose the name of any employee or dependent.

Medical Carrier:	**Renewal Date:**	**# of Plan Participants:**
Dental Carrier:	**401(K) Provider:**	**Ancillary Benefits:**
Vision Carrier:	**FSA / HRA / HSA / Pre Tax Administrator:**	

1. Are any employees or dependents currently pregnant? If yes, What Trimester?	☐**YES** ☐**NO**
2. Are any of the employees currently disabled, hospitalized, or not actively at work?	☐**YES** ☐**NO**
3. Did any employee, dependent, or COBRA participant incur over $5000 in claims in the last 12 months?	☐**YES** ☐**NO**
4. Do any employee or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary or advised that further diagnostic testing is necessary?:	☐**YES** ☐**NO**

Have any employee, dependents or COBRA participants been diagnosed or treated for the following conditions (pre-existing conditions):

5. Cancer / Tumors / Skin Disorders:	**Any form of Cancer or Tumor, any surgery Radiation, or Chemotherapy for Cancer, Psoriasis, Basal Cell Carcinoma, Melanoma:**	☐**YES** ☐**NO**
6. Heart and Circulatory Disorders:	**Heart Attack, Heart Surgery, Chest Pain, Heart Murmur, Stroke, High Blood Pressure, High Cholesterol:**	☐**YES** ☐**NO**
7. Brain and Nervous System Disorders:	**Seizures, Paralysis, Multiple Sclerosis, Migraine Headaches, Depression/Anxiety:**	☐**YES** ☐**NO**
8. Intestinal / Digestive / Kidney Disorder:	**Gastric Reflux Disease, Liver Failure, Hepatitis, Gallbladder Disease, Colitis, Hernia, Kidney Failure, Dialysis, Kidney Stones:**	☐**YES** ☐**NO**
9. Respiratory Conditions / Disorders:	**Asthma, Emphysema, Pneumonia:**	☐**YES** ☐**NO**
10. Endocrine Disorders:	**Diabetes, Lupus, Chronic Fatigue, Thyroid Disorders, Immune Disorders, AIDS / ARC:**	☐**YES** ☐**NO**
11. Musculoskeletal Disorders	**Herniated Disks, Neck / Back Strain, Joint Replacement, Arthritis, Knee or Shoulder Injury, Carpal Tunnel:**	☐**YES** ☐**NO**

12. Are you aware of any employee, dependent, or COBRA participant that has a need for, or are scheduled to have an organ transplant?	☐**YES** ☐**NO**
13. Are you aware of any participants and / or dependents currently eligible for or on COBRA?	☐**YES** ☐**NO**

If any "Yes" answers provided in the above section, please list the details in the grid below. Use additional paper if needed.

Question #	Age	Condition	Treatment	Begin Date	End Date	Medication

I undersigned hereby certified that the information in this ("SRA") Strategy Review Application – General Business Information is correct. In the event that information has been omitted, the insurance carrier may deny or limit coverage for an employee. I certify that all answers and statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind any insurance coverage. Prior to signing below, I reviewed the information contained herein for accuracy and completeness. I understand and authorize Workforce Management Agency Corporation ("WMA") to disclose and furnish this ("SRA") to its corporate partners to determine the availability of various products and services as well as to establish rates for such products and services. I understand failing to meet the Eligibility Requirement or failing to provide accurate and complete information and/or making material misrepresentations to WMA, at any time for any reasons, regardless of cause or fault, may result in rates for certain products and services being adjusted or the products and services being withdrawn, or becoming unavailable altogether. **Additionally, I have been advised by WMA that Company should not cancel any benefit insurance policies currently in place until such time as Company received written notice of acceptance by WMA corporate partnership PEO Company.**

AUTHORIZED COMPANY SIGNATURE:	**DATED:**
PRINT FULL NAME:	**PRINT TITLE:**

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Required Information

- ☐ Copy of your most recent State Unemployment Tax Report
- ☐ Copy of current Worker's Compensation Declaration Page
- ☐ 3 Years WC loss runs, valued within 90 days
- ☐ Payroll Register with breakdown of employee by WC code and state
- ☐ A detailed billing report to include employee gross wages by WC code and state (If currently a PEO client)
- ☐ Current Medical Insurance Invoice
- ☐ Current Invoice or Payroll reports showing current rates (If currently a PEO client)
- ☐ Medical Insurance Plan Designs/Plan Descriptions of all plans offered
- ☐ Employee Census: Showing employee by plan election, and include dependents.
- ☐ If 100+ employees, client must provide 12 months of medical claims experience
- ☐ Annualized Invoice from Third Party Vendor for FSA / H.S.A./ HRA / 401(k) and Pre-tax benefits if applicable

Provide a Brief Description of Operations

List All Entities Subject to Common Ownership

Legal Entity Name	FEIN#	Name of Owner	% of Ownership	Address	Year of Inception

Please mark the box to the right if no Common Ownership Entities Apply above is Not Applicable: ☐N/A

General PEO Underwriting Request

Do you have an EPLI policy? ☐YES ☐NO	**Annual Cost of EPLI:**	**Limit:**	**Deductible:**

Do you use subcontractors? ☐YES ☐NO,
If Yes PEO will likely request a "Subcontractor Questionnaire"

Is any work performed below ground or above 15 feet? ☐YES ☐NO

Do employees that drive as part of their job? ☐YES ☐NO, *If Yes PEO will likely request a " Driving Questionnaire"*

Do you have a current Employee Handbook? ☐YES ☐NO

Do any employees travel outside of the United States? ☐YES ☐NO

Do you have a Written Safety Program? ☐YES ☐NO

Have you had a Reduction in Force or any Layoffs recently? ☐YES ☐NO

Has the company been the subject of any Labor Lawsuits or Labor Dispute in the past 5 years? ☐YES ☐NO, **If yes, please provide details.**

Provide Us With Your Trusted Advisor Contact Information

INSURANCE AGENT:	TEL:	FIRM:
CPA:	TEL:	FIRM:
ATTORNEY:	TEL:	FIRM:
FINANCIAL ADVISOR:	TEL:	FIRM:

AUTHORIZED COMPANY SIGNATURE:	**DATED:**
PRINT FULL NAME:	**PRINT TITLE:**

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