



COMPLETE & FAX TO: (570)386-9933 **ATTN: Group Health Dept.**

Business Name: _____ Business Street: _____

County: _____ **Business Zip Code:** _____ Business Tel: _____

Business Contact Name: _____ Business Fax: _____

Requested **Effective Date:** _____ **Type of Business or SIC Code:** _____

Broker / Agent Name: Harry J. Strauss Agency Name: Strauss Financial

Broker / Agent Tel: (570)386-4574 Fax: (570)386-9933 Email: webmaster@straussinsurance.com

*****IF YOU HAVE MORE THAN 20 EMPLOYEES, PLEASE MAKE EXTRA COPIES OF THIS FORM BEFORE COMPLETING**

	Name of ALL FULL-TIME Employees	SEX	D/O/B	Spouse	#	Residence	STATUS
		M/F		Y/N	Kids	ZIP-CODE	(*Below)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

*STATUS: **E**=(Employee) **ES**=(Employee & Spouse) **EC**=(Employee & Children) **F**=(Family) **W**=(Waiver)



Current Plan Information Needed

- 1) Current Carrier**
- 2) Current Deductible**
- 3) Current Rx Plan**
- 4) Current Office Visit Co-pay**
- 5) Current Broker (if applicable)**
- 6) Copy of Current Bill/Invoice**