701 Healthcare Solutions

Client Consultation Form

Group

Business Name: _____

EIN: ☐☐–☐☐☐☐☐☐☐ SIC: ☐☐☐☐ Number of Employees: _____

Physical Address: _____

City _____ State _____ Zip _____

Mailing Address: _____
**if different from above*

City _____ State _____ Zip _____

Main POC Name: _____

Email: _____ Phone: _____

Do you have multiple office locations? If yes, where? _____

_____

Contribution % Information

Plan Type	Individual	Parent & Child	Parent & Children	Two Person	Family
Health					
Dental					
Vision					

Enter the information the employer would like to contribute.

Notes:

_____

_____

_____

_____

Annual enrollment period: ☐☐/☐☐

Carrier: _____ Plan Name: _____

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Group Census

Name of Employee & Dependents	Job Title	Sex	FT/PT	DOB	DOH	Salary