What if...

We could show you a program that…

- Is Zero Net Cost to the **Employer.**
- Is Zero Net Cost to the **Employee.**
- Employers see an average **savings of $500 per employee per year.**
- Provides a **Medical Reimbursement Account** that can reimburse your employees up to **75% of eligible out-of-pocket incurred medical costs**!
- Provides **Significant Add-On Benefits** to both you and your employees!
- Allows for the **elimination of unnecessary and expensive supplemental health coverage** used to offset high out-of-pocket liabilities.
- This Program **is NOT insurance**! There is no need to change your current health plan or insurance carrier. **It is an Add-On.**
- This unique plan is **100% in compliance** with all codes, rules and regulations with multiple opinion letters.
- There is nothing like this in the marketplace. Let's see if you qualify for this program by filling out a **Questionnaire.**

PROVISION CORPORATION
200 Park Avenue, Suite 1700, New York, NY 10066

Provision ID: 334749

EMPLOYER QUESTIONNAIRE

This questionnaire is only for approval for the purpose of evaluating the potential of providing a solution to the company's premium costs and enhance the benefit on the existing plan. None of this information will be used by us or anyone else for any other purpose.

COMPANY NAME: _____

PHYSICAL ADDRESS: _____

CONTACT NAME: _____ TITLE: _____

COMPANY PHONE NO: _____ CONTACT PHONE NO: _____

CONTACT'S EMAIL ADDRESS: _____

WHAT DOES BUSINESS DO : _____

Seasonal: ❒ yes ❒ no /Times of Yr Company Does Business? _____

TYPE OF BUSINESS: ❒ Sole Proprietorship ❒ Partnership ❒ LLC ❒ Corporation ❒ S-Corp

❒ Other _____

**** FOR PURPOSES OF HIPAA COMPLIANCE, DO NOT PROVIDE ANY NAMES, SS Nos. OR PERSONAL INFORMATION ON THIS FORM ****

1. DO YOU DEDUCT FICA TAXES (SOCIAL SECURITY/MEDICARE)? ❒ yes ❒ no
2. DO YOU PROVIDE A COMPANY GROUP POLICY FOR HEALTH CARE FOR YOUR EMPLOYEES? ❒ yes ❒ no
3. NAME OF INSURANCE COMPANY: _____

   if self-insured, please use page 2 to tell us about your plan, deductible, and what you offer.
4. DO YOU HAVE A SECTION 125 CAFETERIA PLAN? ❒ yes ❒ no
5. IS YOUR HEALTHCARE CONTRACTED THROUGH A: PEO? ❒ yes ❒ no; AN ADVISOR? ❒ yes ❒ no
6. TOTAL NUMBER OF FULL TIME EMPLOYEES: (Must work 30 hrs or more per wk) _____
7. NUMBER OF EMPLOYEES WHO ARE INSURED ON THEIR SPOUSES HEALTHCARE PLAN: _____
8. TOTAL NUMBER OF EMPLOYEES ON YOUR HEALTHCARE PLAN _____

   # Male: _____ # Female: _____
9. *PLEASE FILL OUT THE CHART BELOW* – If there are different plans available, please list:

Employer Healthcare	Plan Type (HMO, PPO, ETC)	Single Deductible	Co-Pay	# Employees on this Plan		For Office Use Only
				# Single	# Family	
Plan 1						
Plan 2						
Plan 3						
Plan 4						
Plan 5						

10. NUMBER OF EMPLOYEES WHO ARE PAID ON COMMISSION OR WHO DO ARE NOT PAID BY SALARY AND ARE ON YOUR HEALTHCARE PLAN _____

11. WHAT PRE-TAX SUPPLEMENTS DO YOU PROVIDE?

❒ FSA ❒ HSA ❒ MRA ❒ 401k ❒ OTHER _____

12. WHAT SUPPLEMENTAL INSURANCE PRODUCTS DO YOU PROVIDE?

❒ Critical Illness ❒ Cancer ❒ Disability ❒ Long Term Care ❒ Group Life _____

(USE EXTRA PAPER FOR ADDITIONAL INFORMATION OR WRITE MORE DETAILS ON BACK OF PAGE)

IF SELF-INSURED PLEASE PROVIDE DETAILS HERE:

_____

_____

_____

_____

By filling out this qualifying questionnaire, you are providing us the ability to assess your current group healthcare situation to evaluate the potential cost to help you, and the return potential for our investment on your behalf, as our OOP assistance is designed to NEVER cost you or your employees anything out of your pockets!

Signature: _____ Date: _____

Print Name_____ Title: _____

Screener Name: _____ Signature: _____Date _____