



# Borshoff & ASSOCIATES

Accountable Business Solutions for Your Future's Benefit

## Benefit Request Form

### General Information:

Group Name: \_\_\_\_\_

Location: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Tax ID: \_\_\_\_\_ County \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Employees: EE: \_\_\_\_\_ Total Insured: \_\_\_\_\_ Part Time: \_\_\_\_\_

### Benefit Requests:

#### Life & AD&D

(min \$10k – max \$50k)

Flat amount \$ \_\_\_\_\_ per employee

Based on Salary \_\_\_\_\_  1x  2x  3x

Classed Benefits (up to 3 classes)

Class 1 \_\_\_\_\_

Class 2 \_\_\_\_\_

Class 3 \_\_\_\_\_

#### Short Term Disability

Weekly Income  1-8-27 weeks  15-15-26 weeks  
Option:

Flat Amount \$ \_\_\_\_\_ Per week  
% of salary (65% max, \$350 per week)

### Health

#### Deductible

\$500  \$1,000

\$2,000  \$2,500

\$3,500  \$5,000

\$7,500  \$10,000

\_\_\_\_\_

#### Out of Pocket Max

\$2,500  \$3,500  \$12,500

\$5,000  \$10,000  \_\_\_\_\_

#### PCS

Copay: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mail: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### Insurance %

HSA  PPO  HRA

50%  70%  100%

80%  90%

Dental:  Ortho:  Maternity:

Vision:  1<sup>st</sup> \$ Accident:

Dr. Office Copay: \_\_\_\_\_

Effective Date: \_\_\_\_\_