**H2 INSURANCE SERVICES, INC.**

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# Group Health Fact Finder

Company Name: _____Contact: _____

Address: _____City: _____Zip: _____

Years in Business: _____ Nature of Business: _____

Do you currently have health insurance? Yes☐ No☐ If yes, with whom:

_____

Type of coverage you are interested in: Health☐ Dental☐ Vision☐

| | Employee Name | Sex | DOB | Coverage* | Spouse DOB | # of Children | Home Zip |
|---|---|---|---|---|---|---|---|
| 1 | | | | - | | | |
| 2 | | | | - | | | |
| 3 | | | | - | | | |
| 4 | | | | - | | | |
| 5 | | | | - | | | |
| 6 | | | | - | | | |
| 7 | | | | - | | | |
| 8 | | | | - | | | |
| 9 | | | | - | | | |
| 10 | | | | - | | | |
| 11 | | | | - | | | |
| 12 | | | | - | | | |
| 13 | | | | - | | | |
| 14 | | | | - | | | |
| 15 | | | | - | | | |
| 16 | | | | - | | | |
| 17 | | | | - | | | |
| 18 | | | | - | | | |
| 19 | | | | - | | | |
| 20 | | | | - | | | |
| 21 | | | | - | | | |
| 22 | | | | - | | | |
| 23 | | | | - | | | |

*EE: Employee only, ES: Employee & Spouse, EC: Employee & Children, F: Family