

Zuleger Advisors

Employee Benefit Solutions

Name of Employer: _____ Effective Date: ____/____/____
Company Contact's Name: _____ Email: _____
Company Address: _____
Company Phone: _____ Company Fax: _____
Worker's Compensation Carrier: _____ Policy Number: _____
List the names of any owners, officers or partners who are not legally required to be covered by Worker's

Compensation, but are eligible to enroll in this health plan: _____

Will this coverage replace your current group health coverage? Yes No
If yes, list your current health insurance carrier and effective date: _____

ELIGIBILITY: All employees working a minimum of 30 hours per week are eligible. If requested in writing, employees working less than 30 but not less than 20 hours per week may be eligible.

Hours Requirement (cannot be greater than 30): _____

Total Number of Employees: _____
Total Number of Eligible Employees: _____
Total Number of Eligible Employees Enrolling: _____
Total Number of Eligible Employees Waiving due to other coverage: _____

Employees must apply within thirty-one (31) days of becoming eligible or they will be considered a late applicant
Employee waiting period:

- _____ None
- _____ 30 Days
- _____ 60 Days
- _____ 90 Days
- _____ 120 Days
- _____ 180 Day

Employee effective date:
_____ First of the month after waiting period
_____ Immediate after waiting period

Do you want new employee currently in their waiting period to be eligible as of the group's plan effective date?
 Yes No

Are any employees or dependents totally disabled, confined to a nursing facility, or hospitalized at the current time?
 Yes No If yes, give names, ages, and date of disability: _____

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