BURAK INSURANCE SOLUTIONS	AN INDEPENDENT INSURANCE AGENT

One Call For All Your Personal and Business Insurance Needs

Dear Potential Applicant:

Thank you for your interest in Burak Insurance Solutions and our expertise in obtaining the most competitive insurance quotes in the industry for the Georgia market. We know how important it is to have the best value for your insurance products.

Please complete the form provided on the following page at your convenience. After completion, please print and fax this form to 770-521-1420. We will review this form for completeness and contact you for any additional information needed to acquire the best quotes.

Again, we thank you for interest and look forward to serving you in the future.

Sincerely,

Frederick L. Burak

Frederick L. Burak

BUSINESS INFORMATION

1. **The information gathered in this form is for the purpose of obtaining a non-binding group insurance quote.**
2. **Answer all questions completely and accurately.**
3. **Do not cancel your existing coverage.**

Company Name			Tax ID Number	
Street Address	City		State	Zip Code
Contact Person Name	Title		Phone	
E-mail Address			Multi – Locations ☐ Yes ☐ No	

Type of Organization

☐ C-Corp ☐ S-Corp ☐ LLC ☐ PC ☐ Independent Contractor ☐ Other:

Nature of Business	Years in Business	Industry SIC Code

Total Employees	# of Full-Time Employees	# of Part-Time Employees	# Applying	# Waiving	# of Hours Per Week to be Eligible	# on Cobra

# Termed in 12 months	Waiting Period for New Hires	Waiting period waived @ Enrollment	# of Employees Outside of Service Area
		☐ Yes ☐ No	None

Name of Current Medical Carrier	# of Years Covered	Name of Current Dental Carrier	# of Years Covered

Employer Medical Contribution	Employer Dental Contribution	Employer Life Contribution	Employer Disability Contribution	Classes Excluded
Single: %	Single: %	Single: %	Single: %	☐ Union
				☐ Non-Union
Family: %	Family: %	Family: %		☐ Other:

Worker's Compensation Carrier Name	Policy Number	Carrier Phone Number	List of Owners/Partners Not Covered by Workers Comp

☐ Yes ☐ No	In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws (chapter 7/11)?
☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity be placed into voluntarily into bankruptcy?
☐ COBRA ☐ State Continuation	Under federal regulations, if your group has 20 or more employees on at lest 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had less than 20 employees, Medicare benefits would be primary.
☐ Medicare Primary ☐ Health Plan Primary	Under federal laws if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary
☐ Yes ☐ No	Are you a member of a "controlled group of corporations" as that term is defined by United States Code section 414 (b) Internal Revenue Code)? If yes, please give the legal names of all other corporations within the control group and the number of employees employed by each.

HEALTH PROFILE

(Complete One Health Profile Per Employee)

☐ Group ☐ Individual ☐ Family | ☐ Life ☐ Health ☐ Disability ☐ Dental

For Group - Employer name, address, phone number, Contact Person name:

Primary Applicant Name	Sex	DOB	Age	Height	Weight	Smoker?

Home Street Address	City	State	Zip Code

Home Phone	Work Phone	Occupation	Payroll Information
			☒ Mgmt ☐ Salaried ☐ Hourly

Medications & Related Condition

Medication Name	Date Stated	Dosage	Frequency	Condition
1.				
2.				
3.				
4.				

Medical Treatment Last 12 Months (attach separate piece of paper if more room needed)

Condition	Date Diagnosed	Treatment & Results

Spouse Name	Occupation	Sex	DOB	Age	Height	Weight	Smoker?

Medications & Related Condition

Medication Name	Date Started	Dosage	Frequency	Condition
1.				
2.				
3.				
4.				

Medical Treatment Last 12 Months (attach piece of paper if more room needed)

Condition	Date Diagnosed	Treatment & Results

Child(ren) Name	Sex	Birth Date	Age	Height	Weight

Medical Treatment For Children Last 12 Months (attach additional page if more room needed)

Child Name	Treatment